CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W00288/5**

TITLE: **Iowa Marketplace Choice Plan**

AWARDEE: **Iowa Department of Human Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Iowa Marketplace Choice Plan section 1115(a) Medicaid demonstration (hereinafter "demonstration") to enable Iowa to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (the Act), and expenditure authority authorizing federal matching of demonstration costs no otherwise matchable, which are separately enumerated. These STCs set forth in detail the nature, character and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective on the date of the signed approval. Enrollment activities for the new adult population began on October 1, 2013 for the Iowa Marketplace Choice Plan with eligibility effective January 1, 2014. The demonstration will be statewide and is approved through December 31, 2016.

The STCs have been arranged into the following subject areas:

II. PROGRAM DESCRIPTION AND OBJECTIVES

Under the Iowa Marketplace Choice Plan demonstration, the State will provide premium assistance and assistance in paying cost sharing for individuals with income above 100 percent of the federal poverty line (FPL) who are eligible in the state plan eligibility group described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (Act) and who are neither medically frail nor eligible for cost-effective employer-sponsored insurance (the Marketplace Choice Plan population), to enable such individuals to enroll in coverage offered by a designated Qualified Health plan (QHP) in the individual market through the Marketplace. Such individuals are ages 19 through 64 with income above 100 percent of the federal poverty line (FPL) up to and including 133 percent of the FPL.

The Iowa Marketplace Choice demonstration contains an incentive program that is intended to improve the use of preventive services and other healthy behaviors. Monthly premiums for enrollees with household incomes above 100 percent of the FPL, up to and including 133 percent of the FPL, will be imposed in year 2 of the demonstration and shall be waived if enrollees complete all required healthy behaviors during year 1 of the demonstration. For each subsequent year, enrollees will have the opportunity to complete healthy behaviors and to continue to have their financial contributions waived based on those activities, i.e., healthy behaviors performed in year 2 will be permitted to waive premiums for year 3.

The authority enabling the state to begin charging premiums in year 2 is subject to a quarterly aggregate cap of 5 percent of family income. We provided authority to relieve the state of its responsibility to not provide non-emergency medical transportation (NEMT) for individuals in the Marketplace Choice demonstration. This waiver authority was originally scheduled sunset after one year, to allow the state and CMS to evaluate impact on access to care. Under the December 2014 amendment, the state will be relieved of its responsibility to assure non-emergency medical transportation (NEMT) through July 31, 2015. Through this demonstration, the state will test and evaluate the effect of this change in state responsibilities on beneficiary access and utilization of services, and overall health status.

The Marketplace Choice Plan population will be entitled to a State plan Alternative Benefit Plan (ABP) specified in the approved state plan. Primary payment for services will be made by the QHP that they select to enroll in. Individuals in this population may have a premium obligation under the terms of this demonstration, but such obligations will be reduced or eliminated for beneficiaries who complete a wellness exam and a health risk assessment. Through the dental amendment, Iowa proposes to further this objective by providing tiered enhanced dental benefits to beneficiaries who demonstrate active management of their oral health through the completion of periodic exam incentives. In addition to the guaranteed basic Core benefits through the Marketplace Choice Alternative Benefit Plan (ABP), beneficiaries who return for a periodic exam within 6-12 months of their first visit will qualify for Enhanced benefits, and Enhanced plus benefits for beneficiaries who return for a second periodic exam within 6-12 months following the first periodic exam.

With this demonstration Iowa proposes to further the objectives of title XIX by:

- Promoting continuity of coverage for individuals who are near the income eligibility threshold for individual coverage by facilitating their enrollment in individual coverage,
- Improving access to providers through the availability of payment for services by QHPs at market rates, and
- Furthering quality improvement and delivery system reform initiatives through incentives for beneficiaries to obtain preventive services and engage in health behaviors.
- Providing supplemental dental services to the QHP and providing tiered Enhanced and Enhances Plus Benefits as incentive to encourage active management of oral health.

Iowa proposes to demonstrate the following key features:

- Whether offering multiple plan options to the Marketplace Choice Plan population that align with options available in the individual market will promote continuity of coverage for individuals;
- Whether the availability of third party payment for services at market rates will improve access to needed services;
- Whether reduced premiums can be an incentive for beneficiaries to use preventative services and engage in other healthy behaviors; and
- Whether removing state responsibility to ensure that beneficiaries have needed non-emergency transportation to and from providers will result in decreased beneficiary access to covered services.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advanced of the expected approval date of the amended STCs to allow the state to provide comment.

4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.

b. If a changes in the federal law mandates programmatic changes that require state legislation, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under federal law.

5. State Plan Amendments. The state will not be required to submit Title XIX or XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances the Medicaid state plan governs.

Should the state amend the state plan to make any changes to eligibility for this population, upon submission of the state plan amendment, the state must notify CMS for demonstration staff in writing of the pending state plan amendment, and request a corresponding technical correction to the demonstration.

6. Changes Subject to the Amendment Process. Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

7. Amendment Process. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 15, prior to submission of the requested amendment;

b. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

c. An up-to-date CHIP allotment neutrality worksheet, if necessary;

d. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation and data supporting the evaluation hypotheses as detailed in the evaluation design in STC 69; and

e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. Extension of the Demonstration. States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the governor or chief executive officer of the State must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of STC 9.

a. Compliance with Transparency Requirements at 42 CFR §431.412.

b. As part of the demonstration extension requests the State must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 15.

9. Demonstration Phase Out. The State may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination: The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The State must submit its notification letter and a draft plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the State must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public

comment received the State's response to the comment and how the State incorporated the received comment into the revised plan.

b. The State must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of activities must be no sooner than 14 days after CMS approval of the plan.

c. Transition and Phase-out Plan Requirements: The State must include, at a minimum, in its plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries determined eligible, as well as any community outreach activities including community resources that are available.

d. Phase-out Procedures: The State must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the State must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category. 42 CFR §435.916.

e. Exemption from Public Notice Procedures 42.CFR §431.416(g). CMS may expedite the federal and State public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR §431.416(g).

10. Post Award Forum. Within six months of the demonstration's implementation, and annually thereafter, the State will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the State must publish the date, time and location of the forum in a prominent location on its website. The State can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The State must include a summary of the comments in the quarterly report as specified in STC 44 associated with the quarter in which the forum was held. The State must also include the summary in its annual report as required in STC 46.

11. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling enrollees.

12. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a transition plan to CMS no later than 6

months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

a. Expiration Requirements: The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

b. Expiration Procedures: The state must comply with all notice requirements found in 42 CFR Sections 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR Sections 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR Section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

c. Federal Public Notice: CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR Section 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.

d. Federal Financial Participation (FFP): FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling participants.

13. Withdrawal of Waiver Authority. CMS reserves the right to amend and withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn or amended, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

14. Adequacy of Infrastructure. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

15. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR Section 431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration are proposed by the state.

a. In states with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR Section 431.408(b)(2)).

b. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR Section 431.408(b)(3)).

c. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

16. Federal Financial Participation (FFP). No federal matching for administration or service expenditures related only to the implementation of this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. POPULATIONS AFFECTED

Under this demonstration, Marketplace Choice Plan Population will be required to enroll in coverage offered by designated QHPs through the Marketplace . The QHPs will pay primary to Medicaid for covered services, and the Marketplace Choice Plan population will be required to receive services from providers that participate in the QHP network instead of the delivery system that serves the traditional Medicaid population. The State will provide premium assistance to aid individuals in the Marketplace Choice population in enrolling in coverage offered by QHPs through the Marketplace.

17. Iowa Marketplace Choice Plan Population. Except as described in STCs 18 and 19, the Iowa Marketplace Choice Plan Demonstration affects the delivery of benefits, to adults aged 19 through 64 eligible under the State plan eligibility group that is described in 1902(a)(10)(A)(i)(VIII) of the Act who have incomes above 100 percent up to and including 133 percent of the FPL. Eligibility and coverage for these individuals is subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State plan, except as expressly waived in this demonstration.

Medicaid State Plan Mandatory Groups	Federal Poverty Line	Funding Stream	Expenditure and Eligibility Group Reporting
Parent and caretaker relatives as well as the childless adults, who are eligible in the new adult state plan eligibility group described in section 1902(a)(10)(A)(i)(VIII) who are neither medically frail nor eligible for cost-effective employer sponsored insurance.	Incomes above 100 percent of the FPL up to and including 133 percent of the FPL	Title XIX	MEG – 1

18. Exemptions. The process for determining whether an individual is medically frail or has access to cost effective employer sponsored insurance is described in the approved Iowa state plan.

19. Option for American Indian/Alaska Native Individuals. Individuals identified as American Indian or Alaskan Native (AI/AN) who are described in the Marketplace Choice population will not be required to enroll in QHPs in this demonstration, but can choose to opt into the demonstration and access coverage pursuant to all terms and conditions of this demonstration. AI/AN individuals who elect to participate in the demonstration will be enrolled in the plan they select and will receive applicable cost sharing protections. Individuals who are AI/AN and who have not opted into the demonstration will receive the ABP available to the new adult group and operated through a fee for service (FFS) system.

V. MARKETPLACE CHOICE PLAN PREMIUM ASSISTANCE ENROLLMENT

20. Marketplace Choice. For the Marketplace Choice Plan population, enrollment in a designated QHP will be a condition of receiving benefits.

21. Notices. Marketplace Choice plan population beneficiaries will receive a notice from Iowa Medicaid advising them of the following:

a. QHP Plan Selection. The notice will include information regarding how Marketplace Choice plan beneficiaries can select a QHP. The state will ensure that the beneficiary authorizes the state to select plans for them if they do not choose a plan

b. Access to Services until QHP Enrollment is Effective. The notice will include the Medicaid client identification number (CIN) and information on how beneficiaries can use the CIN number to access services until their QHP enrollment is effective.

c. Direct State Plan Benefits (supplementing QHP covered benefits). The notice will also include information on how beneficiaries can use the CIN number to access direct state plan benefits. The notice will include specific information regarding services that supplement QHP benefits and are covered directly through Medicaid, what phone numbers to call or websites to visit to access direct services, and any cost-sharing for wrapped services pursuant to STC 31.

d. Appeals. The notice will also include information regarding the grievance and appeals process.

e. Exemption from the Alternative Benefit Plan. The notice will include information describing how Marketplace Choice plan beneficiaries who believe they may be exempt from the Marketplace Choice ABP, and individuals who are medically frail, can request a determination of whether they are exempt from this ABP. This notice will describe how beneficiaries seeking to participate in the Marketplace Choice premium assistance can opt out of the medical frailty screening during the QHP selection process.

22. QHP Selection. The QHP in which Marketplace Choice plan population beneficiaries will enroll will be certified through the Iowa Insurance Division's QHP certification process. The QHPs available for selection by the beneficiary will be determined by the Medicaid agency.

23. Enrollment Process. Individuals in the Marketplace Choice Plan population will begin to enroll during the initial QHP enrollment period (October 1, 2013 – March 31, 2014) through the following process:

a. Individuals will submit a joint application for insurance affordability programs—Medicaid, CHIP and Advanced Premium Tax Credits/Cost Sharing Reductions—electronically, via phone, by mail, or in-person.

b. A Medicaid eligibility determination will be made either through the Marketplace or the Iowa Department of Human Services.

c. Once individuals have been determined Medicaid-eligible in the new adult population, they will have an opportunity to complete the health care needs questionnaire, to be assessed for medical frailty as defined in STC 18. They will also have an opportunity to opt-out of the medical frailty assessment if they prefer to enroll in the Marketplace Choice demonstration. Individuals will be notified of the potential consequences of a medical frailty designation as part of the screen offering an opt-out.

d. A determination of availability of cost-effective employer-sponsored insurance will be made.

e. A determination of AI/AN status and offering option to opt in to Marketplace Choice.

f. Individuals who are determined to be in the Marketplace Choice plan population will have an opportunity to shop among QHPs available to Marketplace Choice plan eligible individuals.

g. The State's MMIS will capture their plan selection information and will transmit the enrollment transactions to the QHP issuers.

h. QHP issuers will issue insurance cards to Marketplace Choice plan enrollees.

i. The State's MMIS will issue payments for premiums on behalf of beneficiaries directly to the QHP issuer.

j. State MMIS premium payments to the selected QHP issuer will continue until the individual is determined to no longer be eligible for Medicaid; the individual selects an alternative plan during the next open enrollment period; or the individual is determined to be medically frail or has access to cost effective ESI.

k. In the event that an individual is determined eligible for coverage through the Marketplace Choice Plan, but does not select a plan, the State ensure that the beneficiary authorizes the state to select plans for them if they do not choose a plan.

24. Disenrollment. Enrollees in the QHP as part of Marketplace Choice plan may be disenrolled if they are determined to be medically frail after they were previously determined eligible.

VI. PREMIUM ASSISTANCE DELIVERY SYSTEM

25. QHP MOU. The Iowa Medicaid Enterprise and the Iowa Insurance Division shall enter into a memorandum of understanding (MOU) with each QHP that will enroll individuals covered under the Demonstration within 60 days of the effective date of the STCs. Areas to be addressed in the MOU include, but are not limited to:

a. Enrollment of individuals in populations covered by the Demonstration;
b. Methods for payment of premiums and cost-sharing amounts on behalf of beneficiaries;
c. Reporting and data requirements necessary to monitor and evaluate the Marketplace Choice plan including those referenced in STC 69, ensuring enrollee access to EPSDT and other covered benefits through the QHP; and
d. Noticing requirements; and audit rights.

26. Qualified Health Plans (QHPs). The State will use premium assistance to support the beneficiary's purchase of coverage for Marketplace Choice plan beneficiaries through Marketplace QHPs.

27. Choice. Each Marketplace Choice Plan population beneficiary will have the option to choose between at least two silver plans offered in the individual market through the Marketplace. The State will pay the full cost of QHP premiums on behalf of the beneficiary.

a. Marketplace Choice plan population beneficiaries will be able to choose from at least two silver plans in each rating area of the State.

b. Marketplace Choice plan population beneficiaries will be permitted to choose among the silver plans offered to Medicaid members. All Marketplace Choice plan beneficiaries will have a choice of at least two QHPs in their geographic area.

c. The Essential Community Provider network requirements will be applied by the state as part of the QHP certification process.

d. Marketplace Choice plan beneficiaries will have access to the same networks as other individuals enrolling in the same silver level QHP.

28. Coverage Prior to Enrollment in a QHP. The State will provide direct coverage through Medicaid from the date an individual is determined to be in the Marketplace Choice plan population until the individual's enrollment in the QHP becomes effective.

29. Family Planning. Family planning services that the QHP considers to be out-of-network, subject to all third party liability rules, will be ensured by the state Medicaid program to be paid at state plan rates.

VI. DENTAL DELIVERY SYSTEM

30. Overview. The Iowa Marketplace will provide dental services through a managed care delivery system known as a Prepaid Ambulatory Health Plan (PAHP).

31. Managed Care Requirements. The state must comply with the managed care regulations published at 42 CFR §438, except as waived herein. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR §438.6. The certification shall identify historical utilization of services that are the same as outlined in the corresponding Alternative Benefit Plan and used in the rate development process.

32. Managed Care Contracts. No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR §438 requirements prior to CMS approval of this demonstration authority as well as such contracts and/or contract amendments. The State shall submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of 60 days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.

33. Public Contracts. Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

34. **Managed Care Dental Benefit Package.** Individuals enrolled in the Iowa Marketplace will receive from the managed care program the benefits as identified in Section VIII of the STCs. Covered dental benefits should be delivered and coordinated in an integrated fashion.

35. **Enrollment Requirements.** The state may require any of the populations identified in Section IV to enroll in PAHPs.

    a. Mandatory enrollment may occur only when the PAHP(s) has been determined by the state to meet readiness and network requirements to ensure sufficient access, quality of care, and care coordination for beneficiaries as established by the state, consistent with 42 CFR §438 and as approved by CMS.

    b. In all areas of the state, individuals will only be permitted to enroll in the single PAHP that serves their area of residence.

    c. All individuals will be automatically assigned to the single PAHP that serves beneficiaries in their area of residence in order to access services in their dental benefits.

36. **Network Requirements**. The state must ensure the delivery of all covered dental benefits, including high quality care. Services must be delivered in a culturally competent manner, and the PAHP network must be sufficient to provide access to covered services to the low-income population. The following requirements must be included in the state's PAHP contracts:

    a. **Special Health Care Needs.** Enrollees with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 C.F.R. §438.208(c)(4).

    b. **Out of Network Requirements.** The PAHP must provide demonstration populations with all demonstration program benefits under their contract and as described within these STCs and must allow access to non-network providers when services cannot be provided consistent with the timeliness standards required by the state.

37. **Demonstrating Network Adequacy**. Annually, the PAHP must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate range of providers necessary to provide covered services for the anticipated number of enrollees in the service area.

    a. The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:
        i. The number and types of dentists and dental specialty providers available to provide covered services to the demonstration population
        ii. The number of network providers accepting the new demonstration population; and

iii. The geographic location of providers and demonstration populations, as shown through GeoAccess or similar software.

b. The state must submit the documentation required in subparagraphs i – iii above to CMS with initial PAHP contract submission as well as at each contract renewal or renegotiation, or at any time that there is a significant impact to the PAHP's operation, including service area expansion or reduction and population expansion.

VII. BENEFITS

38. Iowa Marketplace Choice Plan Benefits. Individuals affected by this demonstration will receive benefits described in the Iowa Marketplace Choice alternative benefit plan.

39. Direct Medicaid Benefits. The State will ensure payment under the State plan for ABP benefits that are not covered by QHPs. These benefits include Early Periodic Screening Diagnosis and Treatment (EPSDT) services for individuals participating in the demonstration who are under age 21**.**

40. Access to Direct State Plan Benefits. In addition to receiving an insurance card from the applicable QHP issuer, Marketplace Choice plan beneficiaries will have a Medicaid CIN through which providers may bill Medicaid for direct state plan benefits. The notice containing the CIN will include information about which services Marketplace Choice plan beneficiaries are direct Medicaid benefits and how to access those services. This information will also be posted on Iowa Department of Human Service's Medicaid website and be provided through information at the Department of Human Service's call centers and through QHP issuers.

41. Non-Emergency Medical Transportation (NEMT). Individuals affected by this demonstration shall not receive any benefit in the form of administrative activity or service to assure non-emergency transportation to and from providers. This waiver authority will sunset on July 31, 2015, to allow for reevaluation of this authority. The state and CMS will consider the impact on access to care.

42. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). The State must fulfill its responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions) of the Act.

43. FQHC and RHC Services. At least one QHP in each service area will contract with at least one FQHC and RHC, where FQHC or RHC services are available.

44. Dental Wellness Plan. Individuals affected by this demonstration will qualify for Enhanced or Enhanced Plus dental benefits earned through the completion of periodic exam incentives. Benefits are explained in Table 1. The State must provide member hotline assistance to individuals seeking dental care who were unable to secure an appointment with a dental provider. The State must take action to assist beneficiaries in accessing services if they report

to the State, in a timely manner, that they were not able to secure a dental appointment through the PAHP. Where attempts to make an appointment have been verified, but the beneficiary was still unable to access services, the State must provide an exemption to the periodic exam incentive requirements to any beneficiary who has a demonstrable dental need for services contained in either the Enhanced or Enhanced Plus earned benefit tiers.

Table 1. Dental Wellness Plan Benefits under the Demonstration

	Enhanced	Enhanced Plus (subject to prior authorization)
Benefits Available	All Core benefits as described in the Wellness ABP and the following: • Restorations and other restorative services • Root Canals, apexification, apicoectomy, and other endodontic services • Non-surgical gum treatment • Denture adjustments, repairs, relines (limit 2 per 12 months) • Non-surgical and surgical extractions and other Oral Surgery services • Designated adjunctive services	All Core benefits as described in the Wellness ABP, all Enhanced Benefits, and the following: • Crowns/onlays – for anterior permanent teeth with extensive coronal destruction/broken cusp and posterior teeth with root canal therapy and cracked tooth syndrome • Tooth Replacements: o Dentures (partial) – for replacing anterior teeth and posterior teeth when there are fewer than eight teeth in occlusion or when required to balance the occlusion o Dentures (Complete) –for edentulous o Bridges (only covered for designated clinical conditions in which a partial denture is contraindicated. • Gum Surgery
Beneficiary Action to Earn Benefits	Return for a periodic exam within 6 – 12 months of first visit*	Return for a second periodic exam within 6 – 12 months of the first periodic exam*.

	*** The initial follow up visit is either the first follow up visit upon enrolling into the Iowa Health and Wellness Plan and receiving the first exam OR the first follow up visit after starting over due to non-compliance**.	*** The first periodic exam refers to when the beneficiary became eligible for Enhanced Benefit Tier.**
Beneficiary Action to Maintain Earned Benefits	Return for 1 periodic exam every 6 – 12 months of previous periodic exam.	Return for 1 periodic exam every 6-12 months from previous periodic exam.

Beneficiaries who return for a periodic exam within 6 – 12 months of first visit will qualify for enhanced benefits. Beneficiaries who return for a second periodic exam within 6 – 12 months of the first periodic exam will qualify for additional enhanced benefits (Enhanced Plus). Failure to comply with the periodic exam incentives described in Section VIII. for maintaining earned benefits will preclude the beneficiary's further access to Enhanced or Enhanced Plus services and the beneficiary will revert to the Core benefits described in the Marketplace Choice ABP. Beneficiaries have access to all emergency services in the Core benefit if they are unable to access the Enhanced or Enhanced Plus tiers. Beneficiaries will be able to challenge any denial in whole or in part, limited authorization of service, termination of a previously authorized service, of failure of a plan to act within the required timeframe as described in Section IX of the STCs.

VIII. HEALTHY BEHAVIORS, PREMIUMS AND COST SHARING

45. Premiums.

a. Authority to charge premiums is subject to the CMS approval of the protocols described in STC 49.
b. No premium will be charged for the first year of enrollment in the Iowa Marketplace Choice Plan.
c. All premiums in this section are subject to the exemptions and waivers described in STC 37.
d. Monthly premium amounts may not exceed $10/month for nonexempt households between 100-133 percent of the FPL.
e. Enrollees will be allowed a 90 day premium grace period.

46. Premium Exemptions. Iowa Marketplace Choice Plan enrollees will be exempt from a monthly contribution obligation under the following conditions:

a. For all individuals enrolled in the Iowa Marketplace Choice Plan, premiums are waived in the first year of the individual's enrollment. Premiums will continue to be waived in subsequent years if enrollees complete healthy behaviors in their prior annual period as outlined in the Healthy Behavior Incentive Protocol once approved as Attachment A.

b. Premiums may only be assessed on non-exempt individuals as described in 42 CFR 447.56.

c. All individuals who self-attest to a financial hardship will have no premium obligation. The opportunity to self-attest will be made available with each invoice.

47. Copayment for non-emergency use of the emergency department. Premiums shall be in lieu of other cost sharing except that the state may impose a copayment for non-emergency use of the emergency room consistent with its approved state plan and with all federal requirements that are set forth in statute, regulation and policies, including exemptions from cost-sharing set forth in 42 CFR § 447.56.

48. Iowa Marketplace Choice Healthy Behaviors. Authority to implement the Healthy Behaviors component is subject to the CMS approval of the protocols described in 49. Enrollees who do not complete required healthy behaviors will be required to pay their monthly premiums beginning in the next enrollment year.

a. **General Description**. All individuals subject to premiums who are enrolled in the Iowa Marketplace Choice Plan will have premiums waived in year 1 and will be eligible to receive a waiver of monthly premium contributions required in year 2 of enrollment if enrollees complete healthy behaviors during year 1 of enrollment. For each subsequent year, nonexempt enrollees will have the opportunity to complete healthy behaviors to continue to waive financial contributions, i.e. healthy behaviors performed in year 2 will be permitted to waive premiums for year 3.

b. **Healthy behaviors**. The conditions to be met by a nonexempt individual in year 1 of enrollment as a condition for not being liable for monthly contributions in year 2 are completing a health risk assessment and wellness exam (annual exam). A health risk assessment is considered part of the individual's medical record and is afforded all associated privacy and confidentiality protections afforded to such documents by federal and state law, regulations, and policy.

c. **Grace Period.** Nonexempt individuals will be given a 30 day healthy behavior grace period. If the individual completes the required healthy behaviors in the first 30 days of year when premiums are due, no premiums will be due for the remainder of the year.

49. Healthy Behaviors and Premiums Protocols. Authority to charge premiums and to implement the Healthy Behaviors component described in this section shall apply to the extent that the state establishes the protocols, subject to CMS approval, described here:

a. Year 1 Healthy Behaviors and Premiums Protocols. By March 31, 2014, the state shall submit for approval a protocol describing the state's plan for implementing year 1 Healthy Behavior Incentives and Premiums including, at a minimum, the following:

Healthy Behaviors

i) The purpose and objectives of the Healthy Behaviors Incentive program.

ii) The methodology for obtaining, and content of, the health risk assessment used to identify unhealthy behaviors such as alcohol abuse, substance use disorders, tobacco use, obesity, and deficiencies in immunization status.
iii) The criteria to be met for completing a wellness exam.
iv) The process by which an enrollee is deemed compliant with healthy behaviors in year 1.
v) The positive incentives that could be used both for purposes of reducing premiums or other health-related purposes, and the amount of positive incentives that can be earned on an annual basis which should be at least as much as the annual premium contributions required.
vi) A list of stakeholders consulted in the development of the protocol.
vii) A description of how healthy behaviors will be tracked and monitored at the enrollee and provider levels, including standards of accountability for providers.
viii) A description of how the state will notify and educate enrollees about the Healthy Behaviors Incentives program.

Premiums

ix) The process by which the state will identify individuals who are exempt from the premium requirements
x) The notices beneficiaries will receive regarding premiums and/or Healthy Behaviors and the schedule for such notices.
xi) The process by which beneficiaries will be able to remit payment, including ways individuals who cannot pay by check will be accommodated.
xii) The process by which the state will collect past due premiums.

b. **Future Year Healthy Behaviors Incentives Standards**. By August 1, 2014 (and succeeding years), the state will submit for approval, the protocol with the following Healthy Behaviors Incentive Program standards:
   i) A description of any provisions that will be provided to assist enrollees in addressing unhealthy behaviors identified through the health risk assessment.
   ii) A description of selected healthy behaviors to be met by an individual in year 2 (or subsequent years), whereas, an individual will be deemed compliant with healthy behaviors resulting in a waiver of monthly contributions in year 3 (or subsequent years). Iowa will further evaluate, define and refine healthy behavior requirements for subsequent years of the demonstration. Iowa must obtain CMS approval before the state can introduce new requirements to enrollees.

c. **Premium Monitoring Protocols**. By August 1, 2014, the state will submit for approval, criteria by which the state will monitor premiums and thresholds for modification and/or termination of premium collection in the event of unintended harm to beneficiaries. This monitoring shall include data related to premium payment/non-payment. The state shall include the data it will report to CMS in quarterly reports which must include but are not limited to the number of:
   i) Individuals subject to premium requirements (i.e. number of nonexempt individuals),
   ii) Individuals whose premiums have been waived due to compliance with healthy behaviors,

iii) Individuals exempt due to hardship.
iv) Individuals disenrolled due to premium non-payment.
v) Individuals with overdue premiums including those with premiums past due less than and greater than 90 days.
vi) Information about the state's collection activities.

d. **CMS Review of the Protocols.** Once approved by CMS, the Healthy Behaviors and Premiums Protocols will become Attachment A of these STCs, and will be binding upon the state. The state may request changes to the approved Healthy Behaviors and Premiums Protocols, which must be approved by CMS, and which will be effective prospectively.

IX. APPEALS

Beneficiary safeguards of appeal rights will be provided by the State, including fair hearing rights. No waiver will be granted related to appeals. The State must ensure compliance with all federal and State requirements related to beneficiary appeal rights. Pursuant to the Intergovernmental Cooperation Act of 1968, the State may submit a State Plan Amendment delegating certain responsibilities to the Iowa Insurance Division or another state agency.

Dental services appeals are governed by the contract between the State and the dental managed care organization.

X. GENERAL REPORTING REQUIREMENTS

50. General Financial Requirements. The State must comply with all general financial requirements under Title XIX, including reporting requirements related to monitoring budget neutrality, set forth in Section XII of these STCs.

51. Reporting Requirements Related to Budget Neutrality. The State must comply with all reporting requirements for monitoring budget neutrality set forth in Section XII of these STCs.

52. Monthly Monitoring Calls. CMS will convene periodic conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration; including planning for future changes in the program or intent to further implement the Marketplace Choice plan beyond December 31, 2016. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The State and CMS will jointly develop the agenda for the calls. Areas to be addressed include, but are not limited to:

a. Transition and implementation activities,
b. Stakeholder concerns,
c. ACO and MCO operations and performance,
d. Enrollment,
e. Cost sharing,
f. Quality of care,

g. Access,
h. The benefit package,
i. Audits,
j. Lawsuits,
k. Financial reporting and budget neutrality issues,
l. Progress on evaluations,
m. Legislative developments, and
n. Any demonstration amendments the state is considering submitting.

53. Quarterly Progress Reports. The state will provide quarterly reports to CMS.

a. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration, including the reports documenting key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. For the dental benefit, the State must report on a quarterly basis how many people had a dental need but could not access an appointment in a timely manner based on member services call data.

b. Monitoring and performance metric reporting templates are subject to review and approval by CMS. Where possible, information will be provided in a structured manner that can support federal tracking and analysis.

54. Compliance with Federal Systems Innovation. As MACBIS or other federal systems continue to evolve and incorporate 1115 waiver reporting and analytics, the State shall work with CMS to revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems.

55. Demonstration Annual Report. The annual report must, at a minimum, include the requirements outlined below. The State will submit the draft annual report no later than 90 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted for the demonstration year (DY) to CMS.

a. All items included in the quarterly report pursuant to STC 44 must be summarized to reflect the operation/activities throughout the DY;
b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately; and
c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement;

56. Final Report. Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

XI. GENERAL FINANCIAL REQUIREMENTS

This project is approved for Title XIX expenditures applicable to services rendered during the demonstration period. This section describes the general financial requirements for these expenditures.

57. Quarterly Expenditure Reports. The State must provide quarterly Title XIX expenditure reports using Form CMS-64, to separately report total Title XIX expenditures for services provided through this demonstration under section 1115 authority. CMS shall provide Title XIX FFP for allowable demonstration expenditures, only as long as they do not exceed the pre-defined limits on the costs incurred, as specified in section XII of the STCs.

58. Reporting Expenditures under the Demonstration. The following describes the reporting of expenditures subject to the budget neutrality agreement:

a. Tracking Expenditures. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and Section 2115 of the SMM. All demonstration expenditures subject to the budget neutrality limit must be reported each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, and consistent with annual CSR reconciliation, cost settlements must be recorded on the appropriate prior period adjustment schedules (forms CMS-64.9 Waiver) for the summary line 10B, in lieu of lines 9 or l0C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the SMM. The term, "expenditures subject to the budget neutrality limit," is defined below in STC 60.

b. Cost Settlements. For monitoring purposes, and consistent with annual CSR reconciliation, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (form CMS-64.9P Waiver) for the summary sheet sine 10B, in lieu of lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the SMM.

c. Premium and Cost Sharing Contributions. To the extent Iowa collects premiums, Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 summary sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by DY on the form CMS-64 narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to

demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

d. Pharmacy Rebates. Pharmacy rebates are not considered here except as applicable to the dental services. Pharmacy rebates applicable to the dental services must be reported on Forms CMS-64.9 Waiver or 64.9 Waiver schedules and allocated to forms named for different EG described below as appropriate. In the calculation of expenditures subject to the budget neutrality expenditure limit, pharmacy rebate collections applicable to demonstration populations shall be offset against expenditures.

e. Use of Waiver Forms for Medicaid. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limit (Section XII of these STCs). The State must complete separate waiver forms for the following eligibility groups/waiver names:

i. MEG 1 – "New Adult Group"

f. The first Demonstration Year (DY1) will begin on January 1, 2014. Subsequent DYs will be defined as follows:

Demonstration Year 1 (DY1)	January 1, 2014	12 months
Demonstration Year 2 (DY2)	January 1, 2015	12 months
Demonstration Year 3 (DY3)	January 1, 2016	12 months

59. Administrative Costs. Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name State and Local Administration Costs ("ADM").

60. Claiming Period. All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 and Form CMS-21 in order to properly account for these expenditures in determining budget neutrality.

61. Reporting Member Months. The following describes the reporting of member months for demonstration populations:

a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the State must provide to CMS, as part of the quarterly report required under STC 53, the actual number of eligible member months for the demonstration populations defined in STC 17. The State must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

   To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member months.

62. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The State must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

63. Extent of FFP for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below, subject to the limits described in STC 61:

a. Administrative costs, including those associated with the administration of the demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan.

c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

64. Sources of Non-Federal Share. The State must certify that the matching non-federal share of funds for the demonstration are state/local monies. The State further certifies that such funds shall not be used as the match for any other federal grant or contract, except as

permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-federal share of funding.

c. The State assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid State plan.

65. State Certification of Funding Conditions. The State must certify that the following conditions for non-federal share of demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-federal share of funds under the demonstration.

b. To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for Title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under Title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c. To the extent the State utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for federal match.

d. The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of Title XIX payments.

Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—

including health care provider-related taxes—fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

66. Limit on Title XIX Funding. The State shall be subject to a limit on the amount of federal Title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in STC 60, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the State to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

67. Risk. The State will be at risk for the per capita cost (as determined by the method described below) for demonstration populations as defined in STC 60, but not at risk for the number of enrollees in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the State at risk for changing economic conditions that impact enrollment levels. However, by placing the State at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

68. Calculation of the Budget Neutrality Limit. For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in STC 60 below. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the State may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in STC 62 below.

69. Demonstration Populations Used to Calculate the Budget Neutrality Limit. For each DY, separate annual budget limits of demonstration service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the State under the guidelines set forth in STC 63. The trend rates and per capita cost estimates for each Mandatory Enrollment Group (MEG) for each year of the demonstration are listed in the table below. Revised PMPM totals include the addition of the Dental PMPM expenses.

MEG	TREND	DY 1 - PMPM	DY 2 – PMPM	DY 3 – PMPM
New Adult	4.7%	$ 574.36	$ 601.35	$ 629.63

Group				

a. If the State's experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the PMPM limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the new adult group, the State may submit an adjustment to paragraph (a), along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1of the demonstration year for which the adjustment would take effect.

b. The budget neutrality cap is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across DYs. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.

c. The State will not be allowed to obtain budget neutrality "savings" from this population.

70. Composite Federal Share Ratio. The Composite Federal Share is the ratio calculated by dividing the sum total of federal financial participation (FFP) received by the State on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period (see STC 8), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

71. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

72. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the State's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the State must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved corrective action plan.

Year	Cumulative target definition	Percentage
DY 1	Cumulative budget neutrality limit plus:	3%
DY 2	Cumulative budget neutrality limit plus:	1.5%
DY 3	Cumulative budget neutrality limit plus:	0%

73. Exceeding Budget Neutrality. If at the end of the demonstration period the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

XIII. EVALUATION

74. Submission of Draft Evaluation Design. The state shall submit an amended draft evaluation design including details on evaluation of the healthy behaviors protocol and the dental benefit and delivery system to CMS no later than 60 days after the award of the demonstration, including, but not limited to data that the state proposes to be used to evaluate healthy behaviors and premiums. CMS shall provide comment within 30 days of receipt from the state. The state must employ aggressive state-level standards for statewide access.

75. Submission of Final Evaluation Design. The state shall provide the Final Evaluation Design within 30 days of receipt of CMS comments of the Draft Evaluation Design. If CMS finds that the Final Evaluation Design adequately accommodates its comments, then CMS will approve the Final Evaluation Design within 30 days and attach to these STCs as Attachment B.

76. Cost-effectiveness. While not the only purpose of the evaluation, the core purpose of the evaluation is to support a determination as to whether the preponderance of the evidence about the costs and effectiveness of the Iowa Marketplace Choice plan Demonstration, which provides premium assistance when considered in its totality demonstrates cost effectiveness taking into account both initial and longer term costs and other impacts such as improvements in service delivery and health outcomes.

a. The evaluation will explore and explain through developed evidence the effectiveness of the demonstration for each hypothesis, including total costs in accordance with the evaluation design as approved by CMS.

b. Included in the evaluation will be examinations using a robust set of measures of consumer experience, provider access and clinical quality measures under the Marketplace Choice Plan Demonstration compared to what would have happened for a comparable population in Medicaid.

c. The State will compare total costs under the Marketplace Choice Plan Demonstration to costs of what would have happened under a traditional Medicaid expansion. This will include an evaluation of provider rates, healthcare utilization and associated costs, and administrative expenses over time.

d. The State will compare changes in consumer experience, access and quality to associated changes in costs within the Marketplace Choice Plan. To the extent possible, component contributions to changes in consumer experience, access and quality and their associated levels of investment in Iowa will be determined and compared to improvement efforts undertaken in other delivery systems.

77. Evaluation Requirements. The State shall engage the public in the development of its evaluation design. The evaluation design shall incorporate an interim and summative evaluation and will discuss the following requirements as they pertain to each:

a. The scientific rigor of the analysis;
b. A discussion of the goals, objectives and specific hypotheses that are to be tested;
c. Specific performance and outcomes measures used to evaluate the demonstration's impact;
d. How the analysis will support a determination of cost effectiveness;
e. Data strategy including sources of data, sampling methodology, and how data will be obtained;
f. The unique contributions and interactions of other initiatives; and
g. How the evaluation and reporting will develop and be maintained.

The demonstration evaluation will meet the prevailing standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, interpretation and reporting of findings. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.

The State shall acquire an independent entity to conduct the evaluation. The evaluation design shall discuss the State's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications the entity must possess, how the State will assure no conflict of interest, and a budget for evaluation activities.

78. Evaluation Design. The Evaluation Design shall include the following core components to be approved by CMS:

a. Research questions and hypotheses: This includes a statement of the specific research questions and testable hypotheses that address the goals of the demonstration. At a minimum, the research questions shall address the goals of improving access, reducing churning, improving quality of care thereby leading to enhanced health outcomes, and lowering costs. The research questions will be examined using appropriate comparison groups and studied in a time series. The analyses of these research questions will provide the basis for a robust assessment of cost effectiveness. The amended evaluation design

should include robust metrics and methods for evaluation the healthy behaviors incentives component and dental benefits that take effect on May 1, 2014.

The following are among the hypotheses to be considered in development of the evaluation design and will be included in the design as appropriate:

i. Premium Assistance beneficiaries will have equal or better access to care than if the population were not required to enroll in a QHP, including primary care and specialty physician networks and services.
ii. Premium Assistance beneficiaries will have equal or better access to preventive care services than if they were not required to enroll in a QHP.
iii. Premium Assistance beneficiaries will have lower non-emergent use of emergency room services than if they were not required to enroll in a QHP.
iv. Premium Assistance beneficiaries will have fewer gaps in insurance coverage when their eligibility status changes.
v. Premium Assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers, when their eligibility status changes.
vi. Premium Assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have fewer gaps in plan enrollment, improved continuity of care, and resultant lower administrative costs when their eligibility status changes.
vii. Premium Assistance beneficiaries will have lower rates of potentially preventable emergency department and hospital admissions than if they were not required to enroll in a QHP.
viii. Premium assistance beneficiaries will report equal or better satisfaction in the care provided than if they were not required to enroll in a QHP.
ix. Premium Assistance beneficiaries who are young adults eligible for EPSDT benefits will have satisfactory and appropriate access to these benefits.
x. Premium Assistance beneficiaries will have satisfactory access and experience without a non-emergency transportation benefit.
xi. Premium Assistance will reduce overall premium costs in the Exchange Marketplace and will increase quality of care.
xii. The cost for covering Premium Assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in Iowa Medicaid fee-for-service in accordance with STC 67 on determining cost effectiveness and other requirements in the evaluation design as approved by CMS.
xiii. Premiums incentivize enrollees to complete healthy behaviors.
xiv. Not assuring non-emergency transportation has no impact on healthy behaviors and does not pose a barrier to access to care.
xv. Enrollees will experience greater access to dental providers.
xvi. The monthly premium does not pose an access to care barrier.
xvii. Marketplace Choice Plan enrollees will use preventative care services at a greater rate than if the demonstration were not in place.

b. Study Design: The design will consider through its research questions and analysis plan the appropriate application of the following dimensions of access and quality:

   i. Comparisons of provider networks;
   ii. Consumer satisfaction and other indicators of consumer experience;
   iii. Provider experience ; and
   iv. Evidence of improved access and quality across the continuum of coverage and related health outcomes.

c. The design will include a description of the quantitative and qualitative study design (e.g., cohort, controlled before-and-after studies, interrupted time series, case-control, etc.), including a rationale for the design selected. The discussion will include a proposed baseline and approach to comparison; examples to be considered as appropriate include the definition of control and/or comparison groups or within-subjects design, use of propensity score matching and difference in differences design to adjust for differences in comparison populations over time. The discussion will include approach to benchmarking, and should consider applicability of national and state standards. The application of sensitivity analyses as appropriate shall be considered

d. Study Population: This includes a clear description of the populations impacted by each hypothesis, as well as the comparison population, if applicable. The discussion may include the sampling methodology for the selected population, as well as support that a statistically reliable sample size is available.

e. Access, Service Delivery Improvement, Health Outcome, Satisfaction and Cost Measures: This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that adequately assess the effectiveness of the Demonstration. Nationally recognized measures should be used where appropriate. Measures will be clearly stated and described, with the numerator and dominator clearly defined. To the extent possible, the State will incorporate comparisons to national data and/or measure sets. A broad set of performance metrics will be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation, for meaningful use under HIT, and from the Medicaid Core Adult sets. Among considerations in selecting the metrics shall be opportunities identified by the State for improving quality of care and health outcomes, and controlling cost of care. The State must include a study of network adequacy for dental providers using beneficiary survey data on access.

f. Data Collection: This discussion shall include: A description of the data sources; the frequency and timing of data collection; and the method of data collection. The following shall be considered and included as appropriate:

   i. Medicaid encounter and claims data,
   ii. Enrollment data,
   iii. Provider Network data,
   iv. Consumer and provider surveys, and

v. Other data needed to support performance measurement relative to access and quality metrics.

g. Assurances Needed to Obtain Data: The design report will discuss the State's arrangements to assure needed data to support the evaluation design are available, including from health plans.

h. Data Analysis: This includes a detailed discussion of the method of data evaluation, including appropriate statistical methods that will allow for the effects of the Demonstration to be isolated from other initiatives occurring in the State. The level of analysis may be at the beneficiary, provider, and program level, as appropriate, and shall include population stratifications, for further depth. Sensitivity analyses shall be used when appropriate. Qualitative analysis methods shall also be described, if applicable.

i. Timeline: This includes a timeline for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables.

j. Evaluator: This includes a discussion of the State's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess; how the state will assure no conflict of interest, and a budget for evaluation activities.

79. Interim Evaluation Report. The State is required to submit a draft Interim Evaluation Report 90 days following completion of year two of the demonstration. The Interim Evaluation Report shall include the same core components as identified in STC 72 for the Summative Evaluation Report and should be in accordance with the CMS approved evaluation design. CMS will provide comments within 60 days of receipt of the draft Interim Evaluation Report. The State shall submit the final Interim Evaluation Report within 30 days after receipt of CMS' comments. The State must provide an interim evaluation on access during the first 12 months of access to the enhanced dental benefit.

80. Summative Evaluation Report. The Summative Evaluation Report will include analysis of data from Year Three of the Premium Assistance Demonstration. The State is required to submit a preliminary summative report in 180 days of the expiration of the demonstration including documentation of outstanding assessments due to data lags to complete the summative evaluation. Within 360 days of the expiration date of the Premium Assistance Demonstration, the State shall submit a draft of the final summative evaluation report to CMS. CMS will provide comments on the draft within 60 days of draft receipt. The State should respond to comments and submit the Final Summative Evaluation Report within 30 days.

81. The Final Summative Evaluation Report shall include the following core components:

a. Executive Summary. This includes a concise summary of the goals of the Demonstration; the evaluation questions and hypotheses tested; and key findings including whether the

evaluators find the demonstration to be budget neutral and cost effective, and policy implications.

b. Demonstration Description. This includes a description of the Demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.

c. Study Design. This includes a discussion of the evaluation design employed including research questions and hypotheses; type of study design; impacted populations and stakeholders; data sources; and data collection; analysis techniques, including controls or adjustments for differences in comparison groups, controls for other interventions in the State and any sensitivity analyses, and limitations of the study.

d. Discussion of Findings and Conclusions. This includes a summary of the key findings and outcomes, particularly a discussion of cost effectiveness, as well as implementation successes, challenges, and lessons learned.

e. Policy Implications. This includes an interpretation of the conclusions; the impact of the Demonstration within the health delivery system in the State; the implications for State and Federal health policy; and the potential for successful Demonstration strategies to be replicated in other State Medicaid programs.

f. Interactions with Other State Initiatives. This includes a discussion of this demonstration within an overall Medicaid context and long range planning, and includes interrelations of the demonstration with other aspects of the State's Medicaid program, and interactions with other Medicaid waivers, the SIM award and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid.

82. State Presentations for CMS. The State will present to and participate in a discussion with CMS on the final design plan, post approval, in conjunction with STC 69. The State will present on its interim evaluation in conjunction with STC 70. The State will present on its summative evaluation in conjunction with STC 71.

83. Public Access. The State shall post the final approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report on the State Medicaid website within 30 days of approval by CMS.

a. For a period of 24 months following CMS approval of the Summative Evaluation Report, CMS will be notified prior to the public release or presentation of these reports and related journal articles, by the State, contractor or any other third party. Prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

84. Electronic Submission of Reports. The State shall submit all required plans and reports using the process stipulated by CMS, if applicable.

85. Cooperation with Federal Evaluators. Should CMS undertake an evaluation of the demonstration or any component of the demonstration, or an evaluation that is isolating the effects of Premium Assistance, the State shall cooperate fully with CMS and its contractors. This includes, but is not limited to, submitting any required data to CMS or the contractor in a timely manner and at no cost to CMS or the contractor.

86. Cooperation with Federal Learning Collaboration Efforts. The State will cooperate with improvement and learning collaboration efforts by CMS.

87. Evaluation Budget. A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.

88. Deferral for Failure to Provide Summative Evaluation Reports on Time. The State agrees that when draft and final Interim and Summative Evaluation Reports are due, CMS may issue deferrals in the amount of $5,000,000 if they are not submitted on time to CMS or are found by CMS not to be consistent with the evaluation design as approved by CMS.

XIV. MONITORING

89. Evaluation Monitoring Protocol. The State shall submit for CMS approval a draft monitoring protocol no later than 60 days after the award of the Demonstration. The protocol is subject to CMS approval. CMS shall provide comment within 30 days of receipt from the State. The State shall provide the final protocol within 30 days of receipt of CMS comments. If CMS finds that the final protocol adequately accommodates its comments, then CMS will approve the final protocol within 30 days.

a. The monitoring protocol, including metrics and network characteristics shall align with the CMS approved evaluation design.

b. The State shall make the necessary arrangements to assure that the data needed from the health plans to which premium assistance will apply, and data needed from other sources, are available as required by the CMS approved monitoring protocol.

c. The monitoring protocol and reports shall be posted on the State Medicaid website within 30 days of CMS approval.

90. Quarterly Evaluation Operations Report. The State will provide quarterly reports to

CMS. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration and whether there has been progress toward the goals of the demonstration, including the reports will document key operational and other challenges, to what they attribute the challenges and how the challenges are being addressed, as well as key achievements and to what conditions and efforts they attribute the successes.

91. Annual Discussion with CMS. In addition to regular monitoring calls, the State shall on an annual basis present to and participate in a discussion with CMS on implementation progress of the demonstration including progress toward the goals, and key challenges, achievements and lessons learned.

92. Rapid Cycle Assessments. The State shall specify for CMS approval a set of performance and outcome metrics and network characteristics, including their specifications, reporting cycles, level of reporting (e.g., the State, health plan and provider level, and segmentation by population) to support rapid cycle assessment in trends under premium assistance and Medicaid fee-for-service, and for monitoring and evaluation of the demonstration.

XV. HEALTH INFORMATION TECHNOLOGY AND PREMIUM ASSISTANCE

93. Health Information Technology (HIT). The State will use HIT to link services and core providers across the continuum of care to the greatest extent possible. The State is expected to achieve minimum standards in foundational areas of HIT and to develop its own goals for the transformational areas of HIT use.

a. Health IT: Iowa must have plans for health IT adoption for providers. This will include creating a pathway (and/or a plan) to adoption of certified electronic health record (EHR) technology and the ability to exchange data through the State's health information exchanges. If providers do not currently have this technology, there must be a plan in place to encourage adoption, especially for those providers eligible for the Medicare and Medicaid EHR Incentive Program.

b. The State must participate in all efforts to ensure that all regions (e.g., counties or other municipalities) have coverage by a health information exchange. Federal funding for developing health information exchange (HIE) infrastructure may be available, per State Medicaid Director letter #11-004, to the extent that allowable costs are properly allocated among payers. The State must ensure that all new systems pathways efficiently prepare for 2014 eligibility and enrollment changes.

c. All requirements must also align with Iowa' State Medicaid HIT Plan and other planning efforts such as the ONC HIE Operational Plan.

XVI. T-MSIS REQUIREMENTS

On August 23, 2013, a State Medicaid Director Letter entitled, "Transformed Medicaid Statistical Information System (T-MSIS) Data", was released. It states that all States are expected to demonstrate operational readiness to submit T-MSIS files, transition to T-MSIS,

and submit timely T-MSIS data by July 1, 2014. Among other purposes, these data can support monitoring and evaluation of the Medicaid program in Iowa against which the premium assistance demonstration will be compared.

Should the MMIS fail to maintain and produce all federally required program management data and information, including the required T-MSIS, eligibility, provider, and managed care encounter data, in accordance with requirements in the SMM Part 11, FFP may be suspended or disallowed as provided for in federal regulations at 42 CFR 433 Subpart C, and 45 CFR Part 95.

Attachment A

IOWA MEDICAID HEALTHY BEHAVIORS PROGRAM AND PREMIUM MONITORING PROTOCOLS

HEALTHY BEHAVIORS PROGRAM PROTOCOLS

Iowa's Healthy Behaviors Program is designed to influence how consumers interact with their health care system, emphasizing primary care access and utilization. The Healthy Behaviors Program is designed to reward members through 1) encouraging completion of healthy behaviors by rewarding them with waiver of contributions (premiums) in subsequent enrollment periods and 2) encouraging completion of additional healthy behaviors by rewarding them with financially-based rewards.[1] Correspondingly, providers will be encouraged to assist members in completion of specific healthy behaviors through related financial incentives described below. Iowa has identified the following goals of the Healthy Behavior Program (HBP) in 2014:

1. Empower members to make healthy behavior changes.
2. Establish future member healthy behaviors and rewards.

- Begin to integrate HRA data with providers for clinical decisions at or near the point of care.
- Encourage members to take specific proactive steps in managing their own health and provide educational support.
- Encourage providers to engage member in completion of the healthy behaviors by offering incentive payments.
- Comply with CMS requirements for Healthy Behaviors Program.

Contribution Waiver for Healthy Behaviors Program

Iowa has designated completion of a Health Risk Assessment (HRA) and a wellness exam as the 2014 healthy behaviors that will qualify members for waiver of their contributions in their subsequent enrollment period.[2]

Healthy Behavior 1: Completion of a Health Risk Assessment

In an effort to improve patient outcomes and engage members in their health care, the Iowa Medicaid Enterprise (IME) has selected an HRA tool called How's Your Health (HYH), that uses a set of patient assessment tools developed by Dartmouth Medical School.[3] HYH has been heavily researched and has generated numerous peer-reviewed publications in major journals.

[1] Financially-based rewards are described in 'Member Rewards for the Healthy Behavior Program' section below.
[2] All members who enroll in IHAWP in 2014 will have these Healthy Behaviors. So, if a member enrolls in December 2014, they will need to complete an HRA and wellness exam. Consistent with CMS guidelines, Iowa will select future year Healthy Behaviors by August 1, 2014.
[3] IME developed a Health Risk Assessment white paper that is available at: http://www.dhs.state.ia.us/uploads/HRA%20Whitepaper_03122014_Final.pdf

Also appealing to Iowa is that HYH has been specifically tested with Safety Net providers on the low income population.[4]

HYH covers a wide range of health-related domains including: experience of care, socioeconomic status, functional capacity, confidence with self-management, health habits (smoking, exercise), burden of pain and emotional problems, and community/family support among other factors. HYH is an online tool in English and Spanish written at the eighth grade reading level. A person with computer access can take the assessment in 15 minutes (if healthy), but in some cases it may take up to 40 minutes, if a person has very high needs and low computer literacy. The assessment may expand based on specific responses: e.g. if someone identifies themselves as having diabetes, they are asked an additional series of questions about that condition.

In the Iowa Wellness Plan, when a member completes the survey, the response is distilled into a one-page report that the member receives and may also be provided automatically and securely to that member's primary care provider. In the MPC, when a member completes the survey, the response is distilled into a one-page report that the member receives and that they may share with their primary care provider. Providers will be able to use this tool to address the member's self-identified needs such as the need for help to quit smoking or how to begin a weight-loss program. Providers will also be able to address other risk determinants including lack of adequate family/social support, functional limitations, chronic condition management, and the member's potential for emotional or substance abuse disorders. The use of HYH will give providers meaningful information that will improve interactions with the people they serve. The IME is developing a training methodology for providers to ensure their understanding of the HYH tool.

Iowa Wellness Plan providers can earn an additional, one-time payment of $25 to utilize the results of HYH in the course of the member's care, such as during creation of the member's care plan or at the time of a wellness exam.[5] This payment is valid for the HYH tool only and is being offered for the first year of operation. Additional details around how to submit a claim for this additional reimbursement are still being developed.

At a future point for the Iowa Wellness Plan, the IME plans to use HYH by examining the broad domains of need identified through HYH to obtain a sophisticated understanding of population needs. The IME can help medical practices and Accountable Care Organizations (ACOs) identify the number of people in their practice within these domains of need. This enables providers to develop a planned-care management strategy tailored to the population they serve. Smaller practices can collaborate on shared resources based on aggregate needs.

Although members are encouraged to use HYH, any qualified HRA tool will help members achieve their Healthy Behaviors. As part of the Healthy Behaviors notifications members will receive (discussed below in 'Member Notification and Education' section) information about any

[4] John H. Wasson, MD and Regina Benjamin, MD, MBA, "Health Disparity and Collaborative Care," Journal of Ambulatory Care Management 29:3 (July-September 2006): 235-237

[5] This payment is only available to the Wellness Plan provider network.

additional qualified HRAs that may be available for completion.[6] A qualified HRA tool must comply with the following:

- Provide members with a health summary report;
- Report member completion information to the IME; and
- Report basic health data points identified by the IME, such as smoking status

The IME will ensure members are aware of their HRA tool options through the notice and education efforts described in the 'Member Notification and Education' section below.
To ensure members are not charged contributions in their second year of enrollment, the IME will monitor individuals who have completed and HRA and wellness exam. The IME will monitor member completion of the HRA either through reports received from the HYH vendor or through the submission of reports from a provider entity that has been qualified by IME. IME anticipates receiving this information on a monthly basis and will report it to CMS through the Quarterly Progress Reports. Members will be given their enrollment year and an additional 30-day grace period to qualify to have their contributions waived in their subsequent enrollment year. During this grace period, members will also be given the opportunity to self-report completion of the HRA.

Healthy Behavior 2: Completion of a Wellness Exam
Members are encouraged to complete an annual preventive wellness exam as part of an emphasis on pro-active healthcare management. *Wellness: IME is also encouraging primary care providers to engage members in their healthcare through offering an annual incentive payment when at least 50 percent of their patients complete an annual wellness exam.*[7] Wellness exam have been defined by the following codes:

New Patient CPT Codes		Established Patient CPT Codes	
99381	Less than 1 year of age	99391	Less than 1 year of age
99382	1-4 years of age	99392	1-4 years of age
99383	5-11 years of age	99393	5-11 years of age
99384	12-17 years of age	99394	12-17 years of age
99385	18-39 years of age	99395	18-39 years of age
99386	40-64 years of age	99396	40-64 years of age
99387	65 years of age and older	99397	65 years of age and older

Iowa Wellness Plan providers received Informational Letter (IL) NO.1337 on December 19, 2013, to provide further clarification to providers about how to bill for a wellness exam. The IL is available at:
http://www.dhs.state.ia.us/uploads/1337%20Billing%20a%20Wellness%20Exam%20and%20a%20Sick%20Visit%20Revised.pdf

[6] Added per CMS request on 03.24.14 call that IME identify 'monitoring' activities.
[7] The Wellness Exam incentive payment is further described in the Medical Home Bonus Value Index Score (VIS) Document located at: http://www.ime.state.ia.us/iowa-health-and-wellness-plan.html

As mentioned above, IME will ensure members who have completed their healthy behaviors are not charged contributions in their second year of enrollment. IME will monitor member completion of the wellness exam through analysis of the claims data submitted (including claims data from the managed care organization and Qualified Health Plans). IME anticipates receiving this information on a monthly basis and will report it to CMS through the Quarterly Progress Reports. Members will be given their enrollment year and an additional 30-day grace period to qualify to have their contributions waived in their subsequent enrollment year. During this grace period, members will also be given the opportunity to self-report completion of the wellness exam.

Member Financially-Based Rewards for the Healthy Behaviors Program

National studies indicate a positive correlation between specific incentives and reduced health care costs over time. Findings also show rewards for wellness visits result in more favorable outcomes than rewards that involve lifestyle changes such as quitting smoking or weight loss.[8] The reward program will be designed to increase individual responsibility for personal health and support healthier behaviors. The long-term goal is to reduce health care costs for preventable conditions.

The IME intends to implement a healthy behaviors reward benefit in 2015 to further drive the quality of member health and ultimately reduce unnecessary costs. Beyond the potential to earn a waiver of contributions, IME intends to layer the ability for all Iowa Health and Wellness Plan members to earn Financially-Based Rewards consistent with program goals. These rewards are intended to be available only after the waiver of contributions has been earned (if applicable: as those below 50 percent FPL or who have a Medically Exempt status will have no contributions to waive). IME will contract with a vendor to assist with the administration of the reward benefits. Essential functionality for this program includes:

- Interface with IME to determine members eligible for rewards
- Production and issuance of rewards cards
- Tracking of account balances as rewards are added and benefits spent
- Respond to replacement cards
- Open, maintain and close accounts
- Regular reporting on account activity
- Call center/customer service for card services support

Members under 50 percent of FPL and those who are deemed 'Medically Exempt' are able to participate in the Healthy Behaviors program. Because these individuals will not be assessed monthly contributions, beginning in 2015, they will be able to receive the financially-based rewards for completion of their healthy behaviors. Participating in the program will encourage increased responsibility for personal health and support healthier behaviors consistent with the goals of the program.

[8] Kane, et al. Economic Incentives for Preventive Care. Evidence Reports/Technology Assessments, No. 101. Rockville: Agency for Healthcare Research and Quality, August 2004.

Rewards

Rewards will be based on completion of a 'menu-style' of preventive, health-related activities such as completion of a smoking cessation program, annual dental exam, or obtaining chronic disease management education.[9] Members will be eligible to receive rewards after completion of their Healthy Behaviors that exempt them from contributions in their subsequent year of enrollment. Rewards will be financial in nature and will be tied to health care or healthy activities such as over-the counter pharmacy products, tobacco cessation supplies, dental supplies, gym memberships, and weight loss programs. *At minimum, reward amounts will equal the annual contribution amounts in the Iowa Wellness Plan ($60) and in the Marketplace Choice Plan ($120).*

To gain additional information about the functionality of this type of program, Iowa recently issued a Request for Information (RFI). Responses will be permitted until June 11, 2014. The RFI has been included as Attachment A.

Stakeholder Engagement in Protocol Development

Iowa began engaging stakeholder input for the Iowa Health and Wellness Plan by holding public hearings and education sessions. Each hearing included initial details regarding the Healthy Behaviors Program, with the specific activities added into the discussion once finalized. Two public hearings were held in July 2013. Thereafter, another six public hearings were held statewide in conjunction with the State Innovation Model grant outreach. Each session was attended by a variety of community members, providers and stakeholder organizations.

Iowa has also undertaken an extensive and comprehensive stakeholder approach as part of the State Innovation Model (SIM) Design Grant project in the summer and fall of 2013. A broad spectrum of stakeholders were involved, including providers, payers, physicians, practitioners, managed care organizations, and state agencies like Iowa Department of Public Health and Iowa Department on Aging. Iowa also sought consumer input through two specific Consumer Focused workgroups and a series of public meetings called Listening Sessions. One workgroup was tasked with identifying goals and approaches to engaging members in their own health care and encouraging them to be active participants in becoming healthier. All workgroups discussed the importance of member engagement strategies and specifically the Healthy Behaviors Program for the Iowa Health and Wellness Program.

The SIM stakeholder process, a list of stakeholder participants, meeting agendas, meeting minutes, workgroup summaries and the State Healthcare Innovation Plan are all available at: http://www.ime.state.ia.us/state-innovation-models.html.
Iowa also sought input from the Patient-Centered Health Advisory Council and presented the 2014 Healthy Behavior Program for Iowa Health and Wellness Plan at the November 15, 2013 meeting.

[9] Per STC requirements, these activities will be more fully detailed in the 'Future Year Health Behaviors Incentive Standards' document due to CMS on 08.01.14

Additional stakeholder feedback has been received throughout the fall of 2013 with a variety of organizations. A special meeting of the Medical Assistance Advisory Council (MAAC) was held on August 15, 2013. This session focused on details on the Iowa Health and Wellness Plan, and included a discussion on the Healthy Behavior programs. On November 21, 2013, the Healthy Behaviors were again discussed with the full MAAC membership. The meeting was open to the public. The Healthy Behaviors, including member outreach and education, will be a key topic of the upcoming MAAC Executive Committee meeting in April 2014, and the next full council meeting in May 2014.

Other key stakeholder organizations have held meetings on the Iowa Health and Wellness Plan, all meetings including discussion of the Healthy Behaviors Program. Some of the organizations include:

- Iowa Hospital Association
- Iowa Mental Health Planning Council
- Epilepsy Foundation
- Coalition for Family and Children's Services
- Iowa Behavioral Health Association
- Iowa Primary Care Association
- Visiting Nurse Services of Iowa
- Iowa Safety Net Providers
- Iowa State Association of Counties
- Susan G. Komen Foundation, Iowa Chapter
- Family Development and Self Sufficiency Program
- Iowa Rural Health Association
- AmeriCorps

Further, Iowa has accepted written comments from the Child and Family Policy Center.

Specifically related to the HRA requirement, the IME decided to use the HYH tool after meeting with various stakeholders including the following:

Coventry Health Care of Iowa	November 26, 2013
CoOportunity Health	December 5, 2013
University of Iowa Public Policy Center	December 6, 2013
The University of Iowa Alliance	December 17, 2013
UnityPoint Health	December 19, 2013
Meridian Health Plan	December 19, 2013
Treo Solutions	December 24, 2013

From the stakeholders who are provider entities, the IME learned that, if the entity uses an HRA, it is to gauge their members' health status and to subsequently implement incentives to encourage healthier behaviors with the long-term goal of reducing health care costs.[10]

[10] This information was used in development of Iowa's Positive Incentive/Healthy Behaviors Reward Benefit

The University of Iowa Public Policy Center provided HRA research consistent with the information presented by the provider entities. The research showed that HRA are helpful to engage patients in their care and help primary care practices and patients work in close cooperation.[11] Additionally, the IME found that HRAs have been widely used in employer sponsored plan for a number of years as a means to control costs.

The IME has additional stakeholder engagement activities planned wherein the progress of both 1115 waivers, including the Healthy Behaviors Program, will be discussed. On April 9, 2014, the IME will hold the Medical Assistance Advisory Committee (MAAC) Executive Committee meeting. Also during the month of April, the IME will collaborate with Delta Dental to hold eight public meetings throughout the state.[12] Finally, on (or near) May 21, 2014, the IME will hold a MAAC meeting that will be open to the public.[13]

Member Notification and Education

Iowa has taken an active role in informing members that contributions will not be charged in 2014. The State has also communicated to stakeholders that a Healthy Behaviors program is under development and will be used as a mechanism to waive member contributions. The State has contracted with communications firm LS2 Group to help with member outreach and education efforts. The State is working with LS2 Group to develop a communication plan to ensure members receive timely and pertinent information on the Healthy Behaviors Program. Members are currently receiving information about how to select their primary care provider or Qualified Health Plan as part of the enrollment process.[14] Members will begin receiving messages about the Healthy Behaviors Program starting in spring of 2014. Mailings will continue throughout summer and fall. Fall and winter mailings will be targeted to those who have not completed Healthy Behaviors.[15] All messages will include information of how to contact the IME to self-report and appeal completion of Healthy Behaviors. Messages to members include but are not limited to the following:

- Traditional Member Letter Campaign
    - Members will receive two traditional letters. The first letter will be mailed in the month of April, providing members with detailed information about the Healthy Behaviors Program. The first letter will detail how the program benefits the member and how to complete each healthy behavior. The second letter will be mailed to the member in the month of October, serving as a reminder to complete each healthy behavior and emphasizing the possible contribution waiver.

- Member Postcard Campaign

[11] Wasson, J. H., Godfrey, M. M., Nelson, E. C., Mohr, J. J., & Batalden, P. B Microsystems **in health care: Part 4. Planning patient-centered care.** *Joint Commission Journal on Quality Safety*, 2003 *29,* 227–237.

[12] Although the main focus of these meetings will be the Dental Wellness Plan, the IME will present an overview of both 1115 waivers and the Healthy Behaviors Program.

[13] This meeting will serve as IME's 'post award forum' to comply with STC requirement 10 in both 1115 waivers.

[14] See attachments entitled, Sample WellnessPlan Enroll Packet and Sample Enrollment Packet MktplaceChoicePlan

[15] See attachment entitled, HBP member notification timeline

- Three postcards will be developed with information about the Iowa Health and Wellness Plan to encourage enrollment in the programs and promotion of healthy behaviors. The campaign will specifically be geared toward uninsured Iowans and Iowans enrolled in the Iowa Health and Wellness Plan. These direct mail postcards will also be made available to providers and other stakeholders to distribute as they deem appropriate. Distribution will begin in May, continuing over the summer and fall months.

- Member Newsletter
  - A quarterly newsletter will be developed to communicate directly with the member. Distribution of the newsletters will begin in the second quarter (spring) of 2014 and share with members details related to their Iowa Health and Wellness Plan benefits, the Healthy Behaviors Program, and the importance of playing a role in their health care.

- Website Promotion
  - The Iowa Medicaid Enterprise website (www.ime.state.ia.us) will have a webpage specifically targeted to members of the Iowa Health and Wellness Plan. This page will share with members plan details, information on how to communicate with their provider about HRAs and other health concerns. The custom page will be available to members by May 2014.

- Member Email Campaign
  - Members who share an email address during their application process will receive recurring emails from the IME. Emails to members will include instructions on how to complete the HRA process, what to expect and how to prepare for their physical exam. Members will also be provided contact information for assistance with further questions. Member emails will begin during the month of May 2014.

- Social Media Promotion
  - A Facebook page will be created which meets members where they may spend a significant amount of time and increases the likelihood that they may share messaging across their networks.
    - Three Facebook ads will be created to target members and promote healthy behaviors. The ads will be released for public view during the months of June, September, and December.
    - Status updates relating specifically to the Healthy Behaviors Program will be shared with page followers at least twice per month. These posts may then be shared by providers, members, and stakeholders who have an interest in its message through their respective Facebook pages.

The IME will also outreach to stakeholders, providers and the community. Messages will include but are not limited to the following:

- Stakeholder and Provider Outreach
    - Education Toolkit
        - Healthy Behavior Program information and materials will be added to existing toolkits developed for providers, community organizations, and policymakers related to the Iowa Health and Wellness Plan. The toolkit will include a healthy behavior fact sheet/overview, contact information and instructions on how to complete the HRA, talking points for communication with members and clients, and social media suggestions. The toolkit will be released in April 2014.

    - Flyers
        - A total of three promotional flyers will be created with information on the Iowa Health and Wellness Plan and space allotted for contact information of the provider or stakeholder. The flyers are intended for providers and stakeholders to share with clients and community members who may have an interest in Iowa Health and Wellness Plan eligibility. Flyers will be ready for release during the month of May 2014.

    - HRA Reminder Cards
        - To complete the HYH HRA a provider code is needed. Business cards (2”x4”card) will be created to allow for providers to insert their HRA codes and leave with members as a reminder to complete their HRA. This card will also have simple instructions of how to complete the HRA online or over the phone. The card will be available for providers to download by May 2014.

    - Posters
        - To complete one of the healthy behaviors, the HYH HRA, a provider code is needed from the member. One poster will be created, which shares information about the Iowa Health and Wellness Plan as well as a space allotted for providers to include their provider code. These posters can be hung in the provider office to serve as reference to members who will need the code when completing the HRA and staff who may be assisting the member. The poster will be made available to providers through the toolkit mentioned below by May 2014.

- Community Partnership Outreach
    - Newsletter Content
        - Template newsletter content will be made available for the stakeholders own communication. The newsletter content can be targeted toward Iowa Health and Wellness Plan members or or providers. The content will be released as part of a stakeholder toolkit in April 2014.

- Direct Mail Campaign
    - The three aforementioned postcards that will be developed and provided to members will also be made available to stakeholders and providers. These postcards will focus on member healthy behaviors and enrollment into the Iowa Health and Wellness Plan. Providers may distribute the postcards as they deem necessary. Distribution will begin in May, continuing over the summer and fall months.

- ACO Outreach
    - Healthy behavior materials will be shared with ACOs through a toolkit. The toolkit will include a healthy behavior fact sheet/overview, contact information and instructions on how to complete the HRA, talking points for communication with members and clients, and social media suggestions. The information will be shared with ACOs as early as April 2014

To ensure IME effectively reaches members, when returned mail is received, the IME will cross reference the address with the MMIS system to see if there has been an update to the mailing address. If an address has been updated, the mail is repackaged and sent to the new address. Member Services also notifies the IM Call Center of the update address. IME is also exploring additional methods of address verification including: federal database checks, adding address update reminders on member notifications, and calling members if a phone number is available.

Provider Access Standards *(This section applies only to the Iowa Wellness Plan)*
Iowa's current standards for timely access to care under Medicaid managed care will be mirrored in the Iowa Health and Wellness Plan to ensure that the infrastructure for delivering access to members is appropriate.

Statewide or Regional Access Standards[16]

Please see "Access to Care Standards…" below.

Medicaid Network Slots to Member Ratio Standards

Each county must meet provider access standards prior to launching the Wellness Plan Patient Manager Program. There must be a sufficient number of provider slots available, which is generally 1.5 times the number of potential enrollees. Once access standards are met, managed care may begin in the county. This information will be reported in the quarterly and annual reports that Iowa submits to CMS.

[16] Per CMS, STC #24(a)(ix)(1)(a), statewide or regional access standards, is met in the 'Access to Care Standards' section. Enrollment numbers for both plans are available at the following link: http://dhs.iowa.gov/sites/default/files/IHAWPEnrollment%20Maps_April2014.pdf

Access to Care Standards Including Timeliness and Actual Primary Care Utilization

Iowa will ensure ninety-five percent of members reside in counties that meet timely access to care standards as described below. Iowa will implement an alternative but similar set of measures that are currently in place in our managed care programs.[17] Through a random sampling of Wellness Plan providers, Iowa will ensure the following:

- Medical service delivery sites[18] are located within 30 miles of enrolled recipients.
- Patients with urgent symptoms shall be seen within one day of contacting their primary care provider.
- Patients with persistent symptoms shall be seen within 48 hours of reporting of the onset of the symptoms.
- Patient routine visits shall be scheduled within four to six weeks of the date of the patient request the appointment.
- The provider shall provide or arrange for 24-hour, 7-day provider availability to enrolled recipients.

NCQA Element 1B Standards

NCQA Element 1B standards are as follows:

1. Providing access to routine and urgent-care appointments outside regular business hours.
2. Providing continuity of medical record information for care and advice when office is not open.
3. Providing timely clinical advice by telephone when the office is not open (critical factor).
4. Providing timely clinical advice using a secure, interactive electronic system when the office is not open.
5. Documenting after hours clinical advice in patient records.

From our research the NCQA Element 1B after-hours access standards are not "pass/fail" but based on a range of percentage points depending on how many factors are met. In Element 1B, factor 3 must be met along with two other factors to receive a score of 50 percent. Achieving factor 3 with three other factors must be met to receive a score of 75 percent. Achieving all five factors receives a score of 100 percent.

Iowa is a rural state. People living in rural towns routinely drive 20-30 miles for employment, to get groceries, or to school; they may drive further to reach a hospital or larger health provider.

[17] Iowa's managed care requirements are detailed in the Iowa Administrative Code 441 Chapter 88; Iowa intends to comply with most but not all these requirements as the NCQA criteria described below are slightly different than the managed care requirements. Iowa's Managed care rules are located at the following link: https://www.legis.iowa.gov/docs/ACO/chapter/05-28-2014.441.88.pdf

[18] Medical service delivery sites are expressly defined in the Iowa Administrative Code 441 Sub-rule 88.7(2) and essentially mean all providers who meet the enrollment criteria for IME and therefore have a distinct legacy number in IME's MMIS.

Iowa has many counties with only one small health care provider that may only be open on a part-time basis and may not utilize electronic health records (EHR); Iowa also has counties without a hospital. Therefore a standard that requires ALL five NCQA Element 1B factors to be met in every county or almost every county is not feasible. Considering this, Iowa proposes the following reasonable alternative:

> In 2014, Iowa will ensure that 90 percent of Iowa Health and Wellness Plan members either 1) live in a county that has at least 1 provider that has an NCQA Element 1B score of at least 50 percent or 2) live within 30 miles of a provider that has an NCQA Element 1B score of at least 50 percent.

Reporting on Access to Care and NCQA Standards

On a quarterly basis, Iowa will select 60 providers to take part in a survey that will capture the information detailed above in the sections entitled 'Access to Care Standards Including Timeliness and Actual Primary Care Utilization' and 'NCQA Element 1B Standards.'[19] During each quarter of the calendar year, Iowa will ensure that the providers selected for surveying are unique from those surveyed in previous quarters; this will ensure a total of 240 providers are surveyed annually. Providers will be first selected based on the county in which they practice; this will ensure that at least one provider from each of Iowa's managed care counties are surveyed. After all counties are surveyed, Iowa will conduct random sampling across the state. This will help create a sample of rural and urban providers that is representative of Iowa's Medicaid providers. Iowa will begin conducting this survey in the second quarter of calendar year 2014. Survey results will be reported in the quarterly and annual reports that Iowa submits to CMS.[20]

Data from Monitoring Member Complaints

IME Member Services tracks a variety of data from member phone calls, letters, and emails. IME will continue to track and categorize Iowa Health and Wellness Plan member complaints. Categories of 'Complaints' include:

- Benefits and Services
- Access
- Substance Abuse/Mental Health Access
- Quality of Care
- Medical Provider Network
- Cost Sharing/Contributions
- Healthy Behaviors
- NEMT
- EPSDT

[19] The Access to Care standard requiring medical service delivery sites be located within 30 miles of enrolled recipients will not be captured in the survey. Rather, Iowa will utilize geo access mapping to verify this standard.
[20] This survey process will be conducted in conjunction with the current survey process Iowa has for its MediPASS program. As CMS is aware, the MediPASS survey results are also reported quarterly.

When IME receives member 'complaints,' Member Services will assist the member with the appropriate resolution. IME will also report this information to CMS on the monthly Monitoring Calls and via the Quarterly Reports submitted to CMS.

Data from Consumer Surveys

Iowa will conduct a member survey each year modeled after CAHPS or other member experience surveys. The survey will be performed in an expedited manner to provide compiled survey data during Year 2 to monitor member experience of access as well as care issues. *NOTE: Member experience via survey is also a component of the Value Index Score used in the medical home/ACO incentive program.*

Premium/Contribution Protocols

During their first year of eligibility, all members will be exempt from any contribution payments. This will permit the member the opportunity to 1) gain an understanding of the Healthy Behaviors Program and 2) to complete those Healthy Behaviors that will qualify the member for contribution waiver in the second year of eligibility. In each enrollment year that the member completes the Healthy Behaviors, the member will qualify to have their contributions waived in the subsequent year. During the 2014 enrollment year, members may complete an HRA and a wellness exam to qualify for contribution waiver in the subsequent year. The IME will monitor member completion of the 2014 Healthy Behaviors through analysis of reports sent from the HYH vendor or other provider entity and through analysis of the claims data.

Regardless of whether they complete their Healthy Behaviors, the following members will be exempt from contribution payments:

- Persons with income below 50 percent the FPL
- Persons with a Medical Exempt status
- American Indians/Alaska Natives

These members will, however, have the opportunity receive Healthy Behaviors Rewards for completion the 'menu-style' of preventive, health-related activities that will be further detailed in later reports to CMS.

Members who do not complete their Healthy Behaviors during the first year of enrollment will be subject to the contribution payments in their second year of enrollment. Contributions will be charged as follows:

- Persons with income from 50–100 percent of the FPL = $5 monthly contribution
- Persons with income from 101-133 percent of FPL = $10 monthly contribution

As part of the Healthy Behaviors notice and education, the IME will educate members about these monthly contribution requirements and opportunity to qualify for contribution waiver. More detail about IME's notice and education efforts is described above in the 'Member Notification and Education' section.

The IME will give members a 30 day grace period after their enrollment year to complete their Healthy Behaviors and qualify for contribution waiver. After that time, if the member has not qualified for contribution waiver, the IME will begin sending monthly billing statements including a hardship exemption request form. The billing statement will be mailed to the member prior to the first day of the month in which the contribution is due. Members will have until the last day of the contribution month to either mail in their contribution, or request a hardship exemption for the month. Members may pay by check or with cash. Directions of where to mail the contribution, how to pay in person, how to request a hardship exemption, and who to call with questions will be clearly detailed on the billing statement.

Unpaid contributions will be reflected on the member's next monthly billing statement. *In the Iowa Wellness Plan, all unpaid contributions will be considered a debt owed to the State of Iowa but will not, however, result in termination from the Iowa Wellness Plan. If, at the time of re-enrollment, the member does not reapply for or is no longer eligible for Medicaid coverage, the member's debt will be forgiven.* To further develop this process, policy decisions need to be made in consideration of the operation constraints.

In the MPC, if a member fails to pay any monthly contributions for 90 days, the IME will terminate the member's enrollment status. The member's outstanding contributions will be considered a collectable debt and subject to recovery. A member whose Marketplace Choice Plan benefits are terminated for nonpayment of monthly contributions, must reapply for Medicaid coverage. The IME will permit the member to reapply at any time, however, the member's outstanding contribution payments will remain subject to recovery.

The IME is currently developing the systems structure to effectively monitor the contributions protocols described above. As part of this development, IME will track member completion of each healthy behavior. The IME will ensure this system has the ability to accept healthy behavior completion from a review of claims data as well as through member's self-reporting. The IME will record this information so that it may be reported to CMS on a regular basis, such as through the monthly monitoring calls, quarterly reports, and as requested by CMS.[21] By August 1, 2014, the IME will provide more detailed information about the Future Year Health Behaviors and the Premium Monitoring Protocols as required by the Special Terms and Conditions.[22]

[21] Added per CMS request on 03.24.14 call that IME identify 'monitoring' activities.
[22] See Wellness Plan STC 33 (p. 14, 15) and Marketplace Choice Plan STC 49 (p.18, 19).

IOWA MEDICAID HEALTHY BEHAVIORS PROGRAM

AND PREMIUM MONITORING PROTOCOLS FOR YEAR 2

HEALTHY BEHAVIORS PROGRAM PROTOCOLS

As described in the Iowa's Healthy Behaviors Protocol for Year 1 approved by CMS on July 3, 2014, Iowa's Healthy Behaviors Program is designed to influence how consumers interact with their health care system, emphasizing primary care access and utilization. The Healthy Behaviors Program is designed to reward members through 1) encouraging completion of healthy behaviors by rewarding them with waiver of contributions (premiums) in next enrollment periods and 2) encouraging completion of additional healthy behaviors by rewarding them with financially-based rewards. Correspondingly, providers will be encouraged to assist members in completion of specific healthy behaviors through related financial incentives described below. Iowa has identified the following goals of the Healthy Behavior Program (HBP):

- Empower members to make healthy behavior changes.
- Establish future member healthy behaviors and rewards.
- Begin to integrate HRA data with providers for clinical decisions at or near the point of care.
- Encourage members to take specific proactive steps in managing their own health and provide educational support.
- Encourage providers to engage member in completion of the healthy behaviors by offering incentive payments.
- Comply with CMS requirements for Healthy Behaviors Program.

Contribution Waiver for Healthy Behaviors Program

In Iowa's Healthy Behaviors Protocol for Year 1, Iowa defined the healthy behaviors, a wellness exam and a health risk assessment (HRA), as the behaviors a member must complete to qualify for waiver of contributions in their next enrollment period. As the definition and description of these healthy behaviors was provided in Iowa's Protocol for Year 1 document, further detail will not be provided in this document. Iowa's Healthy Behaviors Protocols for Year 1 is available at: http://dhs.iowa.gov/sites/default/files/FINALHealthyBehaviorsProgramProtocolYear1.pdf
Based on stakeholder and provider feedback[23], Iowa requests to expand the definition of a wellness exam to allow providers more flexibility to make prudent clinical decisions about what level of service is most appropriate for their individual patients. Essentially, providers will be able complete a routine medical examination in lieu of a more comprehensive annual physical depending on the needs of the individual. Allowing the definition of a wellness exam to be expanded retroactively will benefit both the provider and the member. Providers will benefit as they will have more flexibility in completing an appropriate exam for their patients and still receive the incentive for doing so. Members will benefit by having a greater chance to achieve their healthy behaviors and have their contributions waived in their next enrollment year. For

[23] The Iowa Medicaid Enterprise (IME) received requests to expand the definition of a wellness exam from several ACO's, including the University of Iowa Health Alliance, Unity Point and Broadlawns.

more detailed information about the expanded definition of a wellness exam see Informational Letter 1425 Wellness Exam Expanded available in the link below: https://dhs.iowa.gov/sites/default/files/1425%20Healthy%20Behaviors%20Wellness%20Exam.pdf

With CMS approval, Iowa will begin using this expanded definition of a wellness exam with a January 1, 2014 effective date. This expanded definition of a wellness exam will be used for the healthy behaviors program in 2014, 2015, and beyond.

Financially-Based Healthy Rewards for Healthy Behaviors Program (Healthy Rewards)

The healthy rewards portion of the HBP will be designed to allow the member to receive financially-based rewards for completion of set of healthy behaviors defined by the Iowa Medicaid Enterprise (IME).[24] Only members who earn a waiver of contributions in their next enrollment year will be eligible to receive healthy rewards. The member will be encouraged to complete all behaviors simultaneously, but will not receive the finally-based rewards until completion of the wellness exam and HRA have occurred.[25] The behaviors that qualify for rewards will vary annually based on IME's aggregate findings of the HRA as well as input received from the accountable care organizations (ACOs) and the qualified health plans (QHPs). By allowing annual flexibility of the healthy rewards, the IME will be able to address the aggregate areas of need of the total population. Further, allowing flexibility of rewards will give IME the opportunity to explore whether incorporating healthy rewards for completion of social determinates of health activities will be beneficial to the population[26].

On April 24, 2014, the Iowa Medicaid Enterprise (IME) issued a Request for Information (RFI) to further develop the healthy rewards part of the HBP and to detail the role of the vendor. The HBP RFI is available at: http://bidopportunities.iowa.gov/?pgname=viewrfp&rfp_id=10201. The IME accepted comments and input from interested stakeholders and vendors on the member healthy rewards design of the HBP. The IME also held a public meeting May 30, 2014, to allow all interested parties to provide input on the RFI and the healthy rewards of the HBP. Input received varied from suggestions regarding the types of behaviors that should qualify for rewards to the types of rewards that should be offered to the methods of managing the program. The majority of those who provided input stressed the need to keep the program simple enough to be understood by the Iowa Health and Wellness Plan population.

Through input from the RFI responses and comments received at the public meeting, the IME drafted a request for proposal (RFP) to solicit a vendor to manage the healthy rewards portion of the HBP. The vendor will design a rewards program that includes four distinct components necessary to implement and ensure success: the reward benefit itself, member outreach and

[24] The STC's require the rewards to at least be equal to the amount of premiums/contributions to which a member would be subject to pay. The HBP rewards will be at least $120; the exact amount is yet to be determined.
[25] This standard will also apply to persons who are mandatorily exempt.
[26] The IME's HRA captures social determinates of health information and the ACOs are contractually required to address social determinates of health. The IME envisions having more info of the population's needs by calendar year of 2015.

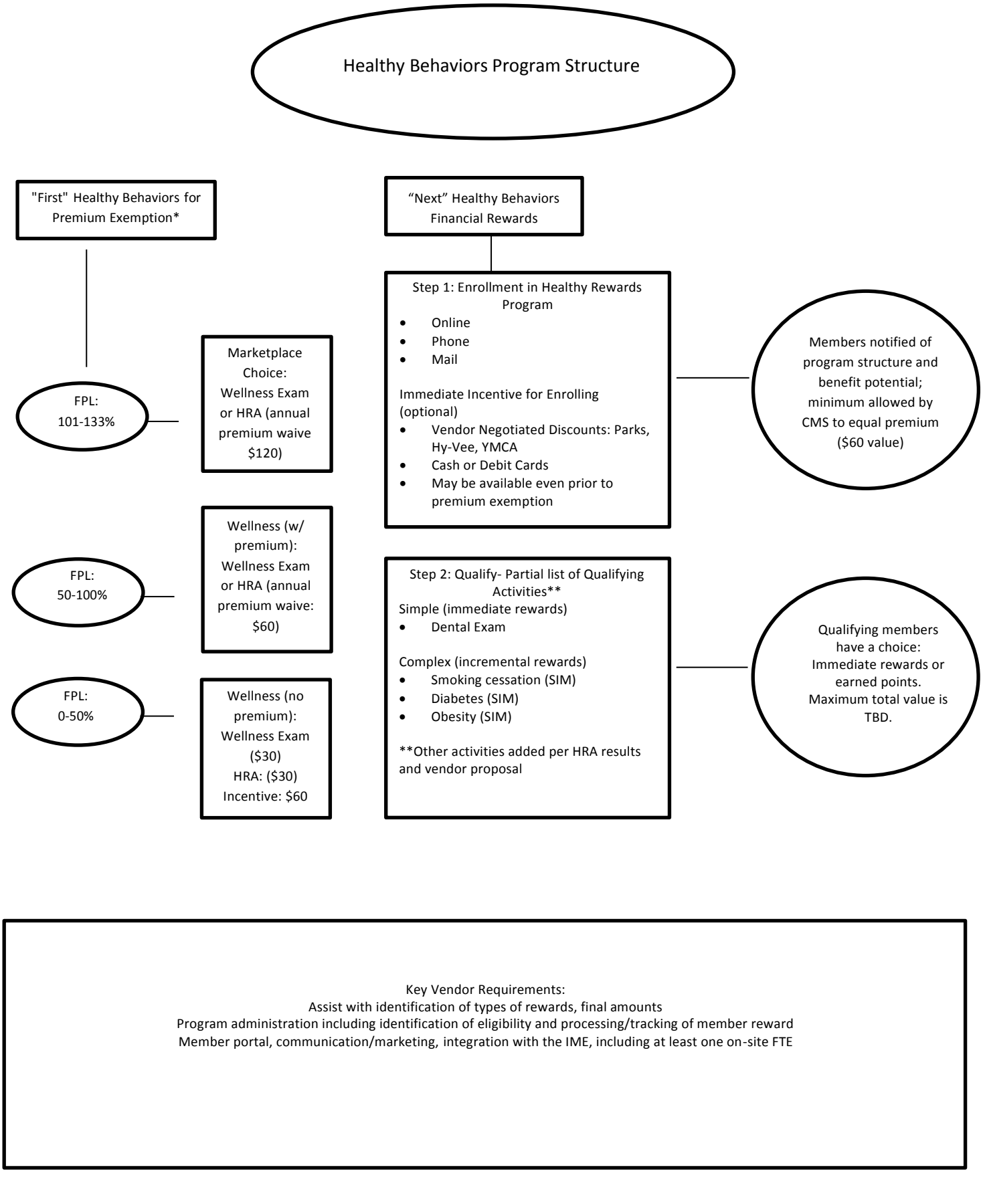
education, engagement of partners and monitoring results. The RFP release and other pertinent dates are listed in the table below.

Event	Date
RFP Notice to Targeted Small Business Website (48 hours)	**July 30, 2014**
Agency Issues RFP to Bid Opportunities Website	**August 1, 2014**
Bidder Letter of Intent to Bid Due By	**August 29, 2014 3:00 p.m.**
Bidder Proposals and any Amendments to Proposals Due By	**October 27, 2014 3:00 p.m.**
Bidder Presentations of Bid Proposals will be held on the following dates via web conference	**November 19-21, 2014**
Agency Announces Apparent Successful Bidder/Notice of Intent to Award	**December 1, 2014**

The RFP may be accessed at: http://bidopportunities.iowa.gov/?pgname=viewrfp&rfp_id=10201

As part of this process, the IME received one RFP. After the IME evaluated the proposal, the IME determined that it was not sufficient to meet the needs of the program. This was largely because the IME did not provide clear direction as to the program's design. To ensure the healthy rewards portion of the HBP is most effective for members, the IME will need additional time to research and develop the best program design. As described above, the IME will review the aggregate findings of the HRA as well as solicit program design input from the accountable care organizations (ACOs) and the qualified health plans (QHPs). The IME will also analyze the results of contribution waiver portion of the HBP including member engagement levels and healthy behavior completion levels, in developing the program design. The IME intends to conduct this research during calendar year 2015 and thereafter, submit to CMS an additional Protocols document with the developed program design.

See the diagram on the following page for additional details.


Healthy Behaviors Program Structure
"First" Healthy Behaviors for Premium Exemption*
"Next" Healthy Behaviors Financial Rewards
FPL: 101-133%
Marketplace Choice: Wellness Exam or HRA (annual premium waive $120)
FPL: 50-100%
Wellness (w/ premium): Wellness Exam or HRA (annual premium waive: $60)
FPL: 0-50%
Wellness (no premium): Wellness Exam ($30) HRA: ($30) Incentive: $60
Step 1: Enrollment in Healthy Rewards Program
Online
Phone
Mail
Immediate Incentive for Enrolling (optional)
Vendor Negotiated Discounts: Parks, Hy-Vee, YMCA
Cash or Debit Cards
May be available even prior to premium exemption
Members notified of program structure and benefit potential; minimum allowed by CMS to equal premium ($60 value)
Step 2: Qualify- Partial list of Qualifying Activities**
Simple (immediate rewards)
Dental Exam
Complex (incremental rewards)
Smoking cessation (SIM)
Diabetes (SIM)
Obesity (SIM)
**Other activities added per HRA results and vendor proposal
Qualifying members have a choice: Immediate rewards or earned points. Maximum total value is TBD.
Key Vendor Requirements:
Assist with identification of types of rewards, final amounts
Program administration including identification of eligibility and processing/tracking of member reward
Member portal, communication/marketing, integration with the IME, including at least one on-site FTE

Healthy Behaviors Program Communication Campaign

The IME has designed an extensive communications campaign to educate the members, providers, and stakeholders about the HBP.

Member Outreach

Members received an initial letter informing them of the HBP in May. That mailing is available at: http://dhs.iowa.gov/sites/default/files/HealthyBehaviors_MemberComm_Wellness.pdf.[27] A second mailing is scheduled to go out to members in early August; this mailing will be targeted to the individual member. The mailing will notify the member which healthy behavior(s) the member has completed (if any) and which healthy behavior(s) the member has yet to complete to avoid contribution payments in the member's subsequent enrollment period.

The IME is also planning to send the following correspondence on or near the dates listed below:

- September 1: Member HBP reminder postcard.
- September 15: Assessment of total HBP completed.
- October 15: Initial contribution notification (if applicable).
- November 15: Member HBP reminder postcard.
- December 15: Second premium notice that will include information the 30-day grace period and information on how to self-report completion of healthy behaviors (in the event that provider has not yet billed for the service).

On July 3, 2014, the IME launched a new website to provide information on the Iowa Health and Wellness Plan and the HBP. On this site, members can access information on benefits, plan details, enrollment information, news and announcements, member materials, and HBP toolkits. This website is accessible at: http://www.iahealthlink.gov/

When HBP vendor is selected, the IME will work with the vendor to develop messaging about the financially-based rewards associated with the HBP. This information will be incorporated into correspondence sent to the member and included on the new website. The IME will work with the vendor to develop communication strategies for a launch in January 2015.

Provider and Stakeholder Outreach

The IME recognizes the importance of engaging providers and stakeholders to assist in helping member complete their healthy behaviors. Pursuing the member through several different avenues will best ensure the member receives information about the HBP and knows where to go with questions.

To assist providers in engaging members, the IME has developed a 'Healthy Behaviors Program Toolkit for Providers' that describes the following:

[27] The first page of this document is the first mailing; the second and third pages are what was included on the double-sided post card sent in the second mailing.

- Why it is important for the member to complete their healthy behaviors;
- The financial incentives a provider may receive for assisting the member;
- Specific details of how the provider needs to bill for the healthy behaviors';
- Members FAQs; and
- Sample promotional information including newsletter content, social media posts, and flyers.

The provider toolkit is available on the IME website at:
http://dhs.iowa.gov/sites/default/files/Provider%20Healthy%20Behaviors%20Toolkit_05092014_2.pdf

To ensure Wellness plan providers and the managed care organization (MCO), Meridian Health Plan, have a thorough understanding of the HBP, the IME provider services unit is providing HBP information at its annual provider enrollment trainings. The IME is holding 22 training sessions in 11 cities located throughout the state. Trainings are being held from June 11, 2014 through August 27, 2014. To date over 1,600 providers have attended or have scheduled to attend trainings. Details about specific dates and training locations are available at:
http://dhs.iowa.gov/ime/Providers/tools-trainings-and-services/ATRegistration/APT

Since April 2104, eleven formal ACO trainings that emphasize HBP have been conducted to ACO provider groups across various Iowa locations. Over 130 ACO staff have participated in the trainings, representing senior leadership at a corporate and regional level for both hospital-based and physician group-based staff. The ACO trainings have taken a top-down approach to engage leadership in an effort to immediately implement processes at the clinic level that will ensure a successful HBP.
Additionally, numerous ad hoc trainings have been conducted for a variety of provider and stakeholder groups. See Attachment 1 – IHAWP Events Tracking Log for more details.

The IME is also providing financial incentives for primary care providers and ACOs who assist members in completing their healthy behaviors. Those incentive payments are described in the chart on the following page.

Payment	Performance	Paid To	Purpose
$4 Primary Care Case Management	Per Member Per Month (PMPM) Paid Monthly	Patient Manager (PM)	Ensures Access
$10 Wellness Exam	Per Member annually if threshold achieved	PM or ACO	Aligns with Healthy Behaviors
$25 HRA AssessMyHealth	To integrate results into member's plan of care	PM or ACO	Aligns with Healthy Behaviors
$4 Medical Home VIS	PMPM – Paid quarterly if quality target achieved	PM or ACO	Aligns w/ multipayer SIM Strategy
$4 ACO Member Engagement	PMPM for member engagement and access activities	ACO	Aligns with Healthy Behaviors & Medicaid Waiver

As of July 1, 2014, there were three ACO's enrolled with Iowa Medicaid: UnityPoint, the University of Iowa Health Alliance, and Broadlawns Medical Center. These three ACO's will facilitate services for over 26,000 members of the Iowa Wellness plan. The ACO's have a vested interest in ensuring their attributed members complete a wellness exam and HRA in that the $4 ACO Member Engagement incentive payment (described above) is contingent upon the ACO achieving a healthy behaviors completion goal for at least fifty percent of their members. The goals are detailed in the chart below.

Organization	Attributed Members	Completion Goal
UnityPoint ACO	7,738	50% = 3,869 Members
UI Health Alliance ACO	11,142	50% = 5,571 Members
Broadlawns Medical Center	7,315	50% = 3,658 Members

The IME is targeting other high volume providers and health plans that do not have ACO affiliation to encourage that they also achieve a fifty percent completion goal. These providers do not have an incentive payment tied to this goal. These providers will, however, receive the incentive payments tied to completion of the wellness exam and HRA completion.

The health plans are actively working with their members to ensure they understand the HBP. Meridian Health Plan is sending letters and phoning members to ensure they complete Meridian's HRA. The QHPs that provide services to members of the MPC[28] are also engaged in informing their members about the HBP. When an MPC member calls the QHP call center, both call centers inform the members of their requirement to complete an HRA and wellness exam so they may continue to be exempt from monthly contributions. Both QHPs have also agreed to provide additional information about the HBP (when available) through their call centers. Both QHPs are also going to add HBP information into their enrollment packet that will be distributed in 2015.

The IME is also working with stakeholders to ensure Iowa Health and Wellness plan members are aware of the HBP. In conjunction with the United Way, the IME formed the Healthy Behaviors Community Partner Steering Committee. The committee will provide advice on community-level outreach, best practices, collaboration opportunities and progress of the HBP. Committee members include the following:

- Key leadership from the Department of Human Services, including Director Palmer;
- IME Communications Manager;
- The United Way;
- Polk County Health Department;
- Broadlawns Medical Center;
- Unity Point ACO;
- The University of Iowa Health Alliance ACO;
- Free Clinics of Iowa;
- The Iowa Department of Public Health; and
- The Iowa Primary Care Association
- Visiting Nurse Services

To ensure stakeholders have the tools to effectively engage member in completing their healthy behaviors, the IME has developed a toolkit that provides fact sheets, talking points, and sample media materials. More details about this toolkit are available at: http://www.iahealthlink.gov/partner-toolkit

To ensure providers and stakeholders have the most up-to-date information about the Iowa Health and Wellness plan, the IME sends weekly updates to an email distribution list of over 700 people. The weekly updates can be accessed at: http://dhs.iowa.gov/ime/about/iowa-health-and-wellness-plan/Archives-Weekly-Iowa-Health-and-Wellness-Plan-Updates

Additionally, all providers and stakeholders have access to the new website launched in July and described above. The website is available at: http://www.iahealthlink.gov/

[28] The QHPs are CoOportunity Health and Coventry Health Care of Iowa.

ACCESS STANDARDS

As discussed in the Healthy Behaviors Protocols for Year 1, the IME will ensure members of the Iowa Health and Wellness plan have sufficient access to providers so that they may complete the healthy behaviors required for contribution exemption. The IME will gauge member access through completion of a provider survey that gathers information about the access to care standards and NCQA Element B1 standards that were detailed (and approved by CMS) in Iowa's Healthy Behaviors Protocol for Year 1. The IME has consulted with a biostatistician from the University of Iowa Public Policy Center (PPC) to develop a survey methodology to capture responses from rural, urban, and near-urban providers. The PPC methodology will ensure the providers surveyed accurately reflect the ratio of providers to which members have access. The PPC methodology categorizes Iowa's 99 counties into four groups and applies a weighted scale to each group based on the population size. The IME will complete this survey by Oct 31, 2014 and report results to CMS at that time. For more details, see Attachment 2 – Iowa Physician Survey Methodology and Attachment 3 – Iowa Physician Survey County Groupings.

The NCQA and Access standards survey results will identify those counties that do and do not meet the access standards. Regarding counties that do not meet the standards, the IME member services call centers will target individual members in those counties through outbound calls to ensure members have an understanding of the HBP and premium waiver mechanism. The call centers will encourage wellness exam completion by ensuring the member is aware of the providers in his area and how to contact their provider to schedule an appointment. Additionally, if the member requests support in scheduling an appointment, the call centers will provide that support. The call centers will also facilitate HRA completion by assisting members in taking the survey over the phone.[29] The IME provider services unit will also attempt to engage the providers who do not meet the standards to encourage them to do so.

As another method of guaranteeing members of the Iowa Health and Wellness plan have sufficient access, the IME has a goal of ensuring at least forty percent of members with income above fifty percent of the Federal Poverty Level (FPL) and who were enrolled in the program on January 1, 2014, complete the healthy behaviors required for contribution exemption. To reach this goal, the IME must have at least 13,656 persons complete the wellness exam and HRA by December 31, 2014.[30]

[29] The call centers are already supporting members in this manner. As of July 31, 2014, the calls centers have assisted over 2,300 members in completing their HRA.

[30] There were 78,148 persons enrolled in the Iowa Health and Wellness plan with an effective date of January 1, 2014. Of those persons, 34,139 had income about 50% FPL. Forty percent of 34,139 = 13,656. In capturing completion rates for this goal, the IME will measure the completion rate of all persons enrolled in the Iowa Health and Wellness plan, regarding of effective date or FPL rate. This will encourage providers to complete healthy behaviors for all their members without scrutiny as to effective date or FPL rate thus ensuring all members are treated equally.

PREMIUM MONITORING STANDARDS

All Iowa Health and Wellness plan members are exempt from monthly contributions during their first continuous twelve months of enrollment. Some members will be mandatorily exempt from monthly contributions by virtue of having a Medically Exempt status, having income below fifty percent FPL, or by being an American Indian/Alaska Native.

A member who does not fit into a mandatorily exempt category will have twelve months of continuous enrollment to complete the healthy behaviors (a wellness exam and HRA) to be exempt from monthly contribution in the next enrollment period. In each enrollment period that the member completes a wellness exam and HRA, the member will be exempt from monthly contributions in the next enrollment period.

Systems Monitoring

The IME Medicaid management information system (MMIS) has been coded to detect all persons who are mandatorily exempt. The IME is also coded to capture those members who complete both a wellness exam[31] and an HRA during a twelve month period of continuous enrollment in the Iowa Health and Wellness plan. Ensuring a member has twelve months of continuous enrollment prior to being subject to monthly contributions will avoid any unintended harm to the member if the member's coverage options change periodically (aka churn). For example, there may be situations wherein the member loses Iowa Health and Wellness plan eligibility if they becomes eligible for another Medicaid program, gains access to employer sponsored insurance (ESI), or their economic situation improves such that they can access insurance through the Health Insurance Marketplace. If the member churns back to the Iowa Health and Wellness plan, the MMIS system will detect that the member had a break in coverage and has not had twelve months of continuous coverage in the Iowa Health and Wellness plan and will therefore not be subject to monthly contributions. Essentially, a break in the member's coverage will begin a new twelve month period during which the member will be exempt from contributions. See the examples below:

Example: Member A

- 01.01.14 enrolled in MPC
- 07.01.14 gains access to ESI and is disenrolled from MPC
- 09.01.14 loses access to ESI, applies for Medicaid and is determined eligible for MPC

Member A did not have 12 months of continuous MPC eligibility. Member A will be exempt from monthly contributions during his enrollment period that begins 09.01.14. Member A will have 12 full months to complete a wellness exam and HRA to continue to be exempt from monthly contributions in the next enrollment year.

[31] This coding is based on the definition of a wellness exam from the Protocols for Year 1 document. Pending CMS approval, the IME will expand the list of codes that count towards completion of a wellness exam.

Example: Member B

- 01.01.14 enrolled in Iowa Wellness plan
- 12.31.14 Member B does not complete healthy behaviors; at re-enrollment she is determined eligible for Mothers and Children (MAC) program
- 01.01.15 – 12.31.15 Member has MAC coverage
- 0.1.01.16 Re-enrollment determines Member is eligible for Iowa Wellness plan.

Although Member B had 12 months of Wellness plan coverage, there has been a 12 month break in that coverage. Member B will be exempt from monthly contributions and have 12 full months to complete a wellness exam and HRA to continue to be exempt from monthly contributions in the next enrollment year.

Member Experience

After a member has been enrolled for ten months and if applicable, the IME will send a reminder notice of the need to complete a wellness exam and HRA to avoid monthly contributions in the subsequent year. A member will receive an initial contribution billing statement during his final month of enrollment. The billing statement will reflect the member's monthly premium amount and instructions on how to claim a hardship exemption. With this initial billing statement the member will also receive notification of the thirty day grace period he will be afforded to report healthy behaviors completion. Essentially, the member will have thirteen months to complete the healthy behaviors or to contact IME member services unit to self-report completion of the healthy behaviors if they were incorrectly recorded as incomplete. This situation could arise, for example, if a provider is not timely with billing a member's wellness exam. If the member completes or reports to be complete the healthy behaviors during this thirty day grace period, the member will be exempt from monthly contributions during the next enrollment year.

A member who is subject to monthly contributions will receive a billing statement before the first day of the month in which the payment is due. The payment or request for hardship exemption will be due by the end of the contribution month. The IME will, however, allow a grace period of five business days before the payment or hardships exemption request is considered past due. A member can pay the contribution by sending a check or money order in the postage paid, self-addressed envelope included with the billing statement. A member may claim a hardship exemption for the month in which the contribution is due by checking the appropriate box on the billing statement or calling the IME member services unit. Payments will be applied to the most outstanding month in which payment is due. Hardship exemption requests will be allowed for the current billing statement.

Member Situation	December 2014	January 2015	February 2015
H.B. complete	End of Dec, receives Jan billing statement and notice of 30-day grace period	Member self-reports H.B. complete, qualifies for exemption from contribution	No contributions due

H.B. NOT complete	Same as above	Member has Jan to pay contribution or claim hardship	Jan contribution or hardship request accepted for 5 business days

In the Wellness plan, members will not be disenrolled for past due contributions. The member will continue to accrue contributions until he goes through the re-enrollment process. If the member does not re-enroll or is no longer eligible for coverage under the Iowa Health and Wellness plan, the IME will review the claims data associated with the member. If the member did not access services after the last contribution payment, the past due contributions will be forgiven. This will allow members who no longer wish to utilize Wellness plan services, perhaps because they have access to ESI, to avoid having outstanding debt with the State. A Wellness plan member who continues to utilize services, does not pay monthly contributions, and who does not re-enroll with the Iowa Health and Wellness plan, will have the unpaid contribution amount sent to the Iowa Department of Inspections and Appeals (DIA) for debt collection.

An MPC member who has unpaid contributions that are at least 90 days past due will have the unpaid contribution amount sent to the DIA for debt collection. An MPC member may also be disenrolled; he may, however, re-enroll at any time by completing a new application.

To appropriately monitor the premium process and member impact, the IME will report the information required by the Special Terms and Conditions in the Iowa Health and Wellness plan quarterly reports. This information will includes but is not limited to the number of:

- Individuals subject to contribution/premiums requirements (i.e. number of nonexempt individuals);
- Individuals whose premiums have been waived due to compliance with healthy behaviors;
- Individuals exempt due to hardship;
- Individuals with overdue premiums including those with premiums past due less than and greater than 90 days;
- Information about the state's collection activities; and
- Individuals who have premiums that have become collectible debt.